

HEALTH AND SOCIAL SERVICES IN HUNGARY

2004 – Year of changes

Compiled by members of staff of the National Institute of Health Information and Library, the National Institute for Family and Social Policy and the Ministry of Health, Social and Family Affairs on behalf of the Ministry of Health, Social and Family Affairs



1051 Budapest
Arany János u. 6-8.
Phone: +36-1-301-7800
www.eszcsn.hu

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Dear Readers,

The year 2004 is a year of major changes for us. If I only mention Hungary's accession to the European Union, you certainly will agree with me. Nonetheless, we are fully aware that we have always belonged to Europe and we firmly believe that we have contributed our spiritual and material values not only to our homeland, but also to Europe; however, a partnership of new dimensions and different quality involves different responsibilities and entails novel challenges. On May 1, as members of a greater community, we adhered to newly agreed community norms and objectives.

We are confident that 2004 will see a turn for the best in many respects. The Hungarian population's health status is alarming in comparison with both the neighboring countries and the European states, which mandates us to do all we can to reverse the negative trends. Hungarians are widely believed to have an inclination to muse about bygone events; yet, we now must turn towards the future, rather than calling past successes or failures to mind. During the accession process, we assessed and explored our situation; today it is time for us to engage in prudent action.

We must implement changes in the healthcare delivery system in order to use our resources more efficiently and appropriately and to increase patient satisfaction. We must implement changes in order to make better use of the traditions of Hungarian medicine and the values of Hungarian healthcare in the European Union. This effort lies in the heart of the healthcare reform which will be growing to full proportions in the years to come.

Furthermore, we have launched a ten-year public health program in order to achieve tangible improvements in the health status of our country's population. We will renew and modernize our social services to ensure that help is delivered to those who need it most and have nobody to turn to.

Living in a healthy environment is a fundamental human right; improving public health, creating and promoting environment conducive to health are responsibilities and basic obligations for all of us.

We have reached an important stage in European environment and health promotion activities: ministers of health and environment from all over Europe will convene for the fourth time, now in Budapest, to consider and review the relationship between the Continent's natural and man-made environments and the European population's health status. The 15-year-old European environment and health process has grown into adolescence, with a receptive mind to novel information, openness to further expanding collaboration, and the intention to have its demands of fundamental significance concerning protection of the environment and promotion of health taken into account in national, regional, and local development plans, projects and programs.

By having agreed to host the Conference 'Future for our Children', Hungary bears evidence of its commitment toward environment and health. Hungary envisions its future as a healthy country in a healthy world, and is ready to take action to achieve its aim and to collaborate with all those who share in this mission. We must start work, without any further delays, to protect future generations from environmental hazards; to this end, we are urging the participating countries to think and act regionally.

Mihály Kökény MD

Minister of Health, Social and Family Affairs



ABOUT OURSELVES

Hungary is a republic with a total territory of 93,000 km². Its capital is Budapest. For administrative purposes, the country is divided into 19 counties and the capital city. The official language is Hungarian.

In 1990, following a peaceful change of the political system, a new, independent democratic state of law was established, with parliamentary democracy based on free elections and a multiparty structure, and new legislation eliminating the barriers of the development of the market economy. In addition to these changes, in the 1990s Hungary faced temporary severe economic decline, unemployment and social polarisation. However, at the end of the 1990s, economic development accelerated, and gave a chance for the country to catch up with Western Europe. (In 2002, the per capita GDP was HUF 1,671,000 => EUR 6,876.)

At the moment, Hungary is a member of the UNO, WHO, the Council of Europe, the Organisation for Economic Co-operation and Development (OECD); it joined the NATO in 1999 and the European Union in May 2004.

Demographic data

The country had 10,142,000 inhabitants on 1 January 2003. The population has been declining gradually since the beginning of the 1980s, as a result of a decreasing birth rate and higher mortality rate. Hungary was the first European country to experience the natural growth indicator turning into a negative figure in 1981. In addition, international comparisons indicated that since the middle of the 1960s Hungary showed deteriorating figures in the mortality rates reflecting the health status of the population of the European countries.

The ageing of the population, which is a general phenomenon in Europe, can also be observed in Hungary.

During the last twenty years, the distribution of population according to family status has changed significantly in Hungary. There has been a gradual decline in the number of those living in marriage and, parallel with this trend, there has been a significant increase in the proportion of unmarried men and women. The number of divorces has also increased: in 1980, 346 divorces took place per 1,000 marriages, but this number went up to 554 in 2002. The forecast of the UN and Central Statistical Office Research Institute of Demography (KSH, NKI) prepared in 2000 indicated two basic processes for Hungary – a continuous and significant decrease in the number of population, and a new period of ageing.

Health status of the population

The health status of the Hungarian population has been extremely unfavourable for many years. Regarding certain diseases and causes of death, Hungary is in a negatively outstanding position in international statistics. There has been no considerable improvement in morbidity or mortality indicators during the last few decades either. The average life expectancy at birth is much lower than in the Member States of the European Union, and the high mortality of middle-aged men is especially unfavourable.



The mortality indicators improved in Hungary in the first two thirds of the 20th century, and they were contradictory in the last third of the century. Mortality patterns around the turn of the century reflect this contradictory demographic and epidemiologic recent past.

After the Second World War, the history of mortality of the Hungarian population can be divided into three separate periods: until the middle of the 1960s, mortality declined, between 1968 and 1993 it increased, and it has been declining again since 1994. Life expectancy practically followed the changes in mortality: between 1949 and 1967 the life expectancy increased, between 1968 and 1993 it declined slightly, and has been growing recently, reaching 72.4 years in 2002.

There has been significant improvement in infant mortality, considered to be one of the most sensitive indicators of the epidemiological situation even a few decades ago. The life expectancy of infants in Hungary has improved similarly to the improvement observed in the developed Western countries, although there was a slight delay.

Looking at age groups, it can be observed that mortality indicators improved only for children and young adults, while at the age of 30, or even more between 35 and 64 years of age there was significant deterioration in the male population for approximately three decades. There was a smaller, temporary deterioration in the total elderly population too. Thus in 1993 the number of deaths reached 150,000, and the mortality rate amounted to 14.6‰. The improvement started from this trough and resulted in a decrease of 14,000 in the absolute number of deaths, and a decline of 1.3‰ in the rate of mortality between 1994 and 2002, while life expectancy increased by 3.0 years.

Thus it is fair to conclude that life expectancy has never been as good among the population aged less than 35 years than now, but the life expectancy of males in the 35-64 year-age-group has deteriorated considerably during the last 30 years. The number and rate of premature mortality are rather high, as 40% of all men and 20% of women who died had been aged less than 65 years at the time of death (2002). Life expectancy at birth increased from 69.3 years in 1990 to 72.4 years in 2002.

In the morbidity pattern, the diseases of the circulatory system have very high share, in 2001 439,000 patients were treated in hospitals due to diseases of this category (more than 15% of hospitalised cases). Hypertension is almost an endemic disease in Hungary. The occurrence of hypertension complications, cerebrovascular disease and ischemic heart diseases (IHD) is also high, and this latter one is the dominant factor of mortality in Hungary.

The records of family practitioners and paediatricians contained more than 470,000 diabetic patients in 2001, i.e., 4.6% of the population are affected by this disease, the prevalence of which is significantly increasing with age. The complications associated with the disease, and turning more and more severe with age, only increase its public health importance.

Since 1990, the number of patients with a pulmonary condition other than TB and registered in continuing care facilities has more than doubled (in 1990, there were 1,712, but in 2002 there were 4,591 such patients per 100,000 population). The most frequent acute respiratory disease is lung asthma, which affects all age groups, and two thirds of the cases are caused by allergy.

Tumours represent a principal category of disease for public health purposes, as approximately 65,000



new malignant tumours are detected each year in health institutions that are mandated to notify these cases. Tumours are significantly more frequent among women aged 19-54 (breast cancer, tumours of the colon, the rectum and the lung), while over the age of 55 years, tumours are more frequent in men (primarily because of lung cancer).

Among the diseases of the digestive system, one of the most frequent diseases is stomach ulcer and duodenal ulcer. Ulcer, which may occur in all ages, is most frequent in those aged over 45 years. It occurs more frequently among men than women. Apart from deaths caused by chronic liver diseases (primarily cirrhosis), the prevalence of these diseases is also high. On the basis of family practitioners' statistics for 2001, 319.3 men and 134.6 women per 10,000 population over the age of 19 years had liver disease.

Diseases of the locomotor system are the most frequent causes of inability to work. The most frequently observed locomotor diseases are spinal diseases, arthrosis, low back pain and osteoporosis. The outstanding importance of these diseases is not only related to their increasing frequency, but also their consequences, including their impact on disability, quality of life and mortality.

Over the age of 50 years, osteoporosis occurs in approximately 900,000 patients, and rheumatic arthritis occurs in approximately 100,000 patients in Hungary. Locomotor diseases cause half of the chronic diseases in people aged over 60 years. The bone density figures of the Hungarian population are the lowest in Europe, and the consequential fracture of the vertebrae present one of the highest numbers. As a result of death following fracture of neck of femur due to osteoporosis, approximately 2,500-3,000 patients are lost each year in Hungary.

Regarding mental diseases, the data of psychiatric institutions provide an approximate picture of the population's morbidity patterns. These data cannot reflect the actual morbidity patterns, because the statistics only contain patients who seek out specialists of psychiatry institutions with their complaints and who have been receiving continuing care. In 2002, 134,791 patients were on the registers, while psychiatry continuing care facilities for children and youth had 17,137 patients aged less than 19 years on their registers. The gender ratio of patients is considered permanent, with nearly two thirds of the patients being women.

Among the diseases registered in psychiatry continuing care facilities, mood disorders and affective disorders occur in the highest number. In 2002, psychiatric continuing care facilities registered 37,022 patients with these diseases. Schizophrenia is frequent too, and it occurs mostly among people aged 20-65 years, and much more women are affected by it than men. A significant number of patients with depression do not turn to a physician, and they are not taken into continuing care. According to Hungarian data, more than 15% of the population has severe depression conditions at least once in their lives.

Epidemiological situation

In Hungary the epidemiological situation is in total favourable, and it is good in European comparison too. Within the framework of the vaccination system, the latest vaccinations and vaccines are gradually introduced, and vaccination coverage exceeds 99%. The number of communicable diseases, including vaccine-preventable communicable diseases, is decreasing. The incidence of TB declined steadily between 1970s and the early 1990s. It was followed by a small but definite increase, which stopped a few years ago, and subsequently, the index started to drop again. In 2002, the TB incidence registered in pulmonology continuing care facilities was 30 per 100,000 population, which is more than twice the EU average.



Concerning HIV infection, Hungary is one of the lowly infected countries. In Hungary the first HIV infections were identified in 1985. Until 2002, in total 1,041 patients were registered with HIV infection. Primarily homosexual transmission dominates, but in the recent years heterosexual transmission has also increased, giving about 3,000 cases of infection.

Lifestyle

Nutrition habits

The nutrition habits of the Hungarian population is characterised by excessive intakes of energy, fat, animal fat, cholesterol, added sugar and salt, and insufficient intake of dietary fibres insufficient consumption of vegetables and fruits, as well as consumption of less than the desirable amounts of whole-meal cereal. The daily average energy intake is much higher than the ideal value in the case of men, and it is especially typical for those belonging to younger age groups. In the case of women, among whom the energy intake is also higher than the desired figure, there is no significant correlation with age. The excess energy intake of men also involves consumption of alcoholic drinks.

In Hungary, the guidelines for healthy nutrition are based on the principles of food and nutrition policy, representing one of its subprogrammes.

Strategic directions:

- continuous monitoring of the dietary habits of the population, regular analysis of the results, assessment of the dietary characteristics and nutrition level of the population;
- education for healthy nutrition,
- development of public catering in such a spirit,
- indication of national nutrition priorities,
- giving priority to the promotion of foodstuffs with more favourable composition, and supply of information for consumers on the product labels.

As a result of improving dietary habits through the measures, experts hope that the average serum cholesterol level will decrease by 7-10% among the adult population, the frequency of overweight and obesity will not increase, and the incidence of Type 2 diabetes will not be higher than that of developed countries, there will be a decrease in the number of nutritional deficiency and mortality caused by severe diseases related to nutrition will drop by 5%. The national nutrition policy, which aims at relying on co-operation with other specific areas (for example, paediatrics, pediatric dentistry, food industry) is intended to serve this purpose.

Overweight and obesity

Obesity is the number one public health problem in Hungary too, affecting more than 1.5 million people, with further 2.7 million people being overweight. Recently, especially the proportion of obese individuals has increased, primarily among women. Overweight is more frequent among men aged less than 40 years, and approximately half of men in this age-group are overweight. Over the age of 65, the proportion of obese people is declining, but it is only a seemingly favourable phenomenon, because as a result of obesity related disease, obese people reach an older age more rarely than their peers of ordinary weight.



Physical activity

One of the reasons for the unfavourable health status of the population is lack of physical exercise. The physical activity of the population in leisure time is not more than 10 minutes a day. Active income earners do the least amount of physical exercises, and their passivity is closely related to the lack of leisure time, which is the result of their efforts to maintain their living standards.

In order to encourage the whole population to do physical exercises regularly, there is a need for intersectoral co-operation, more intensive training and education, training of health professionals in topics related to this field, and monitoring of the physical performance of the population with internationally accepted methods. According to the strategies concerning this area, apart from the measures of political decision-makers, the media should also have a more intensive role in the wider dissemination of the culture of physical fitness.

Smoking

Smoking is the most important risk factor underlying avoidable and premature death, which should be considered a serious endemic disease from a public health point of view. According to the Central Statistical Office, the death of 28,000 people may be attributed to smoking each year in Hungary (2002). At the end of the 1990s, the mortality in the age group of 15-64 years related to smoking was nearly 2.5 times higher than the European Union average, and twice as high as the average of all European countries. In Europe, mortality caused by lung cancer (the disease in strongest relation with smoking) is the highest in Hungary, and the figure keeps increasing.

Reduction of smoking is the number one area of intervention in the public health programme, within which outstanding attention is devoted to the efforts to prevent young people from taking up the habit. The set target is 8% reduction in cigarette consumption by 2005 (in 1999, 2,400 cigarettes/year/person, EU: 1,600), and the reduction of the proportion of regular smokers by 6% by 2010.

One of the instruments in the fight against smoking is the high excise duty content of tobacco products, the amount of which is determined in a directive in the European Union. The government received derogation in reaching this level until 2009.

Alcohol consumption

Alcoholism is a serious health problem in Hungary. In 2000, mortality due to excessive alcohol consumption was more than three times as high as the European Union average for males, and two and a half times higher in the case of females. However, it is a positive factor that the gradual increase of mortality due to alcohol consumption between 1980 and 1995 was followed by a moderate decrease after 1995.

According to the latest surveys, 19.2% of men and 5.1% of women are heavy drinkers, but due to methodological reasons, the actual data are most probably higher than that. Abstinence is decreasing in the case of both sexes, although more significantly among women. In the 1990s, the age group most at-risk was the group aged 50-59 years. The most important positive factor of the last ten years is that in the second half of the 1990s there was a significant decline in the alcohol consumption of people aged 30-39 years. However, a negative phenomenon is that consumption increased in secondary schools, especially among girls. This phenomenon is not just a Hungarian feature. In international comparison, alcohol consumption of secondary school students is not high for the time being. Another negative phenomenon



is that problem drinking is more and more typical of young people. These days alcohol consumption cannot clearly be attributed to a disadvantaged social position, it is increasingly present in all groups of the society.

Alcohol prevention is second to the fight against smoking among the interventions in the relevant health policy program. The policy sets the target of significant reduction of per capita alcohol consumption first (until 2008), followed by considerable reduction (by 2012). Another target is a significant and measurable reduction of psycho-social problems caused by alcohol (including primarily the detrimental impacts on the family and children raised within the family, and alcohol related accidents), as well as significant reduction of the frequency and volume of alcohol consumption by youths.

Drug use

The government ordered a survey first in 1994 which tried to collect detailed data about drug use. As a result of this survey, more or less adequate data have been available since 1995, but it needs to be pointed out that, due to numerous statistical methodological problems, the evaluation of drug use data requires a lot of caution, more than in other areas of the health sector.

According to 2002 data, around 12,700 drug addicts have been treated in health institutes since 1999 (12,000 in 2001). There are more or less twice as many men among them as women. It is a special feature that between 1995 and 1998 the ratio of drug types (licit and illicit) turned around. In this period the proportion of those using legal substances dropped from 67% to 35%, and those consuming illegal substances increased from 33% to 65%. Among the illegal drugs, the consumption of opiates has been the highest all the time and it is still increasing. The number of cannabis (marihuana) users increased from 3% to 11% between 1995 and 1999, with a subsequent drop to 6.9% between 2000 and 2001. Cocaine consumption was low, and practically stagnated between 1995 and 2000, representing only 1.7% of the treated patients. The consumption of hallucinogens was even lower, although there was a 13% increase in consumption in 2001.

Licit drugs include organic solvents and sedatives, and abuse of sleeping pills. A special type of the abuse of sleeping pills consists of taking them together with alcohol (polytoxicomania).

In the second half of the 1990s, the joint life prevalence of illicit drugs and inhalants nearly doubled, and increased from 10% to 19% among second-year secondary school students. The increase, which took place in the second half of the decade, was much higher than the national average in Budapest, increasing from 12.0% to 28.8% between 1996 and 1998. In 1999, only marihuana and amphetamine consumption increased, and then it practically stagnated, although on the basis of the latest survey conducted in spring 2002, the consumption of a few substances, including ecstasy, LSD, cocaine and cannabis derivatives is expected to increase.

Structural and quality changes accompanied the aggravation of the problem in the second half of the 1990s. Intensity of consumption increased, and the first illicit drug use takes place among younger and younger people. The dominant age of the first attempts dropped from 16 years to 15 years. The changes of the volume and intensity of consumption were accompanied by a change in the structure of substances: marihuana and various synthetic party drugs have become more and more popular in youths. Girls, at least in Budapest, have practically „caught up” with boys.



In 1995, illicit substances also occurred beside licit substances in mortality statistics related to drugs, but the data can only be accepted with caution and reservation. The number of deaths due to drugs has not changed significantly during the last few years. Seventy percent of all deaths were registered in Budapest.

Environment and health

In Hungary, the first phase of the National Environmental Protection Programme (NEPP), reflecting the environmental policy, has already been accomplished. The pieces of legislation of environmental protection law approximation have been completed, and the establishment of an institutional system that is aligned to the EU requirements has also started. Objectives were implemented most successfully in the area of nature conservation and protection of clean air, while protection of waters and human health, as well as increase of environmental safety was slightly behind in performance. The second phase between 2003 and 2008 (NEPP-II) relies on the 6th Environmental Action Programme of the European Union, to be implemented until 2010. The health related tasks of NEPP-II are contained in the Environmental Health and Food Safety Action Programme.

Programmes launched from 2000 are expected to bring favourable results for the health status of the population, and to assist competitiveness with environment friendly measures. As a result of cleaner production, and environmentally aware technology and product development, the environmental load has reduced, which will probably lead to a reduction in health damaging effects as well. Development of the potable water supply, sewage collection and treatment, as well as waste management is required in the whole territory of the country.

Food safety

In Hungary, the safety of foodstuffs is of a high level and is regularly controlled. The Hungarian regulations on additives and chemical contaminants in foodstuffs are in harmony with the regulation prevailing in the developed countries. Public health has a very important role in monitoring, and establishment of limit values, as well as licensing procedures. In food hygiene regulations, control takes place within the framework of the HACCP system. In 2002, 2,959 people fell ill as a result of foodborne intoxication and poisoning (the corresponding figures were 3,952 in 1970, 4,395 in 1980 and 3,679 in 1990).

Air quality

At the start of the National Environmental Protection Programme (1997) approximately 13.2% of the territory of the country, where almost 50 per cent of the population live, had more or less polluted air. The main reasons of the pollution included public transport and district heating. The most important elements of air pollution include carbon dioxide, carbon monoxide, sulphur dioxide and nitrogen oxides. As a result of a decline in industrial production, air pollution caused by industry has also declined. Since 1999, no leaded petrol has been sold in Hungary, thus this hazardous environmental pollution source has been eliminated. With the reduction of the sulphur content of fuels and desulphurisation investments of power plants, the sulphur dioxide emission has also reduced significantly. The volume of nitrogen oxide emission from the exhaust gas of mainly internal combustion engines is increasing year by year, and the volume of nitrogen oxide released into the air from the heating systems of the population is also significant.



With the distribution of cars with catalysts the carbon monoxide content of the air has reduced significantly. The air pollution above the limit value of larger cities and settlements alongside main roads increases the risk of respiratory diseases, cardiovascular diseases and related mortality. The number of allergy, asthma and chronic respiratory diseases increases, and the incidence of lung cancer also grows. The number of registered hay-fever patients has increased ten times for the last ten years, while the number of asthma patients has trebled over the same period.

In view of the fact that road traffic is the key factor of air quality in settlements, environmentally friendly transport development has started involving the elaboration of a long-term strategy for transport infrastructure development.

Ragweed, producing pollen with a heavy allergenic effect, is an extremely large environmental health problem. The spread of ragweed has increased significantly by the fact that after the privatisation of arable lands the size of uncultivated land, owned by often unreachable owners, has increased enormously. In Hungary, ragweed exists on approximately 4 million hectares, while the size of areas heavily polluted with weeds is larger than 700,000 hectares. Subsidies and application opportunities offered to local governments and NGOs giving priority to non-chemical weed killing help to reduce the aeroallergens in air originating from uncultivated environment.

Water quality, sewage treatment

Almost the whole population is supplied with mains water. In 2002, mains water supply covered 99.9% of settlements and 93.0% of all homes. The potable water quality requirements are not fully satisfied in 1,300 settlements at the moment. However, in the majority of cases the water quality problems do not represent a health risk in the actual concentration ranges, they are only recorded as so-called aesthetic problems (for example, iron, manganese, ammonium and organic substance content). The presence of nitrite, nitrate, boron and fluoride in an amount higher than the limit value is an important public health problem in approximately 180 settlements (approximately 200,000 inhabitants).

In Hungary, the arsenic risk caused by potable water relates to 1.2 million people, of whom 20,000 are especially exposed to risks. Having cytotoxic, cancerogenic and mutagenic effect even if present only in traces, arsenic accumulates in the organisms of people drinking water with arsenic content during the years, causing significant damages. In Hungary, the arsenic content of potable water is especially high in Southeast Hungary and around Mecsek.

Approximately 80% of the population drink water with low iodine content, which leads to frequent cases of goitre.

Supply of healthy potable water is an objective of the national potable water quality improvement programme, launched in 2003.

The quality of Hungarian surface water is often criticised due to microbiological aspects. The reason for this is that sewage treatment in settlements is much below the quality of water supply. The self-purification capability of waters with a low water yield is significantly exceeded by the degree of pollution.

The measures introduced in order to improve the water quality of Lake Balaton have proved to be successful, through controlling temporary algae formation. It must be noted that for microbiological aspects Lake Balaton is not polluted and at the end of the 1990s first-class water quality was measured in the middle of the lake.



While there is almost comprehensive mains water supply, the proportion of homes connected to the sewage network was 56.0% in 2002, and 36.9% in villages. Although there has been significant development in communal sewage treatment, there are still a lot of tasks in building sewage pipes. The situation is most favourable in Budapest, where more than 90% of the homes have been connected to the sewage system since

1995. According to the plans, additional sewage management projects will be launched in large towns soon.

Urban environment, waste management

Transport, air pollution and noise problems, and inadequate technical conditions of the built environment, as well as lack of green surfaces causes any increasing problem in settlements. In 1998, a new statutory regulation entered into force, introducing restrictions in the noise emission of vehicles, and measures for increased protection against noise and vibration. Despite these efforts, the number of noise and vibration sources has increased, and the noise sensitivity of the population has also increased as a result of the increasing disturbance. Among the environment noise sources, road transport is the most disturbing factor. According to estimates, approximately 30-40% of the Hungarian population live in areas where the noise of transport is higher than allowed (over 60-65 dBA).

Each year, 300-450 kg/capita domestic and similar industrial commercial waste is generated in Hungary each year, most of which is currently deposited. Depositing the communal waste is one of the most urgent issues of the settlements at the moment. The regular solid waste collection network in settlements covered 86.5% of the population in 2001. At the moment, there are approximately 2,600 waste depositaries in the country. The proportion of land fills, satisfying environmental protection requirements, and operated professionally, represents only 28-30%.

Health and social institutions represent a special field in hazardous waste management. In this category, the extension of public utilities of the facilities is extremely difficult, and the lack of space makes it difficult to build additional hazardous waste storage capacities.

The most important objective of waste management regulated by law in Hungary is protection of human health. The elements of this strategy include prevention of waste generation and reduction of the volume of generated waste, promotion of waste utilisation, neutralisation of non-usable waste in line with environmental requirements, and rehabilitation of areas contaminated by waste.

Occupational health

In Hungary, the legal regulations concerning occupational health practically conform to the European Union requirements. The companies satisfy these requirements at various levels, but many companies have integrated the occupational health and safety management system into its management processes.

In Hungary, there has been a decrease in the number of notified accidents at work, occupational diseases and cases subject to increased exposition recently.



HEALTH CARE

Legal and operational environment of the health care system

In Hungary, the Constitution (Act 20 of 1949) declares the right of everybody living in the territory of Hungary “to the highest possible level of physical and mental health.” [Section 70/D Paragraph (1)] In addition, citizens have a right to social security, which involves an entitlement to benefits guaranteeing income for old people, widows, orphans and unemployed who lost their jobs due to reasons other than their own fault, or in the event of ill health and disability [Section 70/E Paragraph (1)]. The state satisfies this obligation through social security and social institutions [Section 70/E Paragraph (2)]. The Constitution sets a task for the Government to define the public system of social and health care, and to arrange for funding for these services [Section 35 Paragraph (1) subparagraph g)].

The above principles were integrated into the Constitution when it was modified on 23 October 1989, representing one of the important stations of the change of the system. Hungarian health services were available for all citizens universally since 1975 as of right, but at the time of the change of régime, the services were made subject to insurance relationship based on contribution payment obligation (‘were put on an insurance basis’), from which large social groups (pensioners, unemployed, etc.) were excluded and there were some groups which were simply left out. The exceptions from contribution payment obligation were gradually reduced, and since 1996 practically all Hungarian citizens have been insured.

The most important operational principle of the health system is solidarity, which means that the insured do not pay risk proportionate insurance premium but an income proportionate contribution pursuant to the main rule. We generally talk about social insurance because of the contribution payment instead of insurance premium payment, which, in addition to the insurance element, also executes a considerable income redistribution too from those with a higher income towards those with a lower income, from the active towards the inactive (pensioners and young people), from the employed towards the unemployed, etc.

The principal piece of legislation in the health sector is the Health Act setting out the most important framework rules of health care (Act 154 of 1997), which replaced its predecessor, which had been effective for 25 years, but became obsolete (Act 2 of 1972). Its scope covers all health service providers operating and health activities pursued in the territory of Hungary, defines the rights and obligations of patients and health care employees, and the state’s responsibility for the health status of the population, the system of health services, the professional requirements of the services, and organisational and management system in the health sector. The Health Act also defines medical research conducted on humans, special procedures involving human reproduction, research with embryos and spermatozoon, basic rules of sterilisation, treatment and care of psychiatry patients, organ and tissue transplants, sets out rules relating to corpses, it also deals with blood supply and emergency health care, medical expert activities, natural medicinal factors, spas and climatic therapeutical institutes and treatment facilities.

The Health Act specifies the obligation of health employees to provide services, and it also introduces the concept of health service providers with an obligation to provide services in a particular area, including also the main rules of on-call and on-duty services. In the process of the change of the system, the Act on Local Governments (Act 65 of 1990) made local governments responsible for arranging for the delivery of



health care services. The local governments are mandated to arrange for the provision of primary health care services. Specialist health care, exceeding the tasks of primary care, is an optional task. Pursuant to the provisions of this act, it is a mandatory task of county governments to provide specialist health care above the primary health care level. Local governments can fulfil their obligation to provide these services not only as owners of outpatient and inpatient specialist institutions, but also in the framework of contracts concluded with the owners of such institutions.

In accordance with the effective legislation, the health sector is currently a diverse, multi-actor system, containing local governments, the state, which is present both as a regulator and an owner, a licensing and supervisory authority operated by the state, the National Public Health and Medical Officer's Service (NPHMOS) and the financing agency, National Health Insurance Fund.

The financing system operates on the basis of the principle that current (operating) expenses are covered from the National Health Insurance Fund, while capital expenditure (refurbishment, development, etc.) is covered by the owners (local governments and the state through various public administration agencies, e.g. ministries). This two-channel or dual financing system stops the involvement of enterprises into health services, because enterprises can recover their costs only through to the sale of services.

The majority of health expenses are covered from the state budget.

A new stage in the development of the health sector was the introduction of the Institutional Act (Act 43 of 2003) for the purpose of introducing new types of operational forms, already existing in other fields of the economy (corporate forms) in order to modernise the health care system. The Institutional Act introduced the concept of public health services (health service partly or fully financed by the budget) established rules for the organisation of public health services, and determined the conditions under which health service providers can provide public health services, and also defined responsibility for the organisation for public health services. The act also provides that local governments may satisfy their obligation to provide health services not only by operating their own service institution, but also through contracts (so-called health service contract), and defined the rules of such contracts too.

The Institutional Act contains the most important rules for the operation of public health service providers, the organisational and professional requirements, the obligation of preparing a professional plan and its content elements, rules for the financial security, control of the supply public health services, method of termination of health service contracts, and the liability for damages caused to patients. The act introduced and defined the concepts of mediation contract and health target assets. The act allowed the corporatization of whole health institutions only.

The Constitutional Court declared this act anti-constitutional for formal reasons, and annulled it with an effective date of 15 December 2003. It did not examine the contents of the act at all. The Ministry intends to cover the key elements of the regulations contained in the Institutional Act in other legal regulations. The work assisting the enforcement of rights of users is becoming increasingly important among health, social and child protection services. The Act 154 of 1997 on health care regulates the rights and obligations of patients widely. It clearly determines the rights relating to health services, human dignity, maintaining contact, information, self-determination, study of documentation, rejection of services, and physician's confidentiality. The act sets an obligation for the service providers to inform patients about patient rights. It also identifies the tasks of operating a patients' rights advocacy system in order to enhance awareness, enforcement and protection of rights.



Management of the Health Care System

Ministry of Health, Social and Family Affairs

In Hungary the social and welfare systems are managed and supervised by the Ministry of Health, Social and Family Affairs, with the exception of unemployment benefits (unemployment benefit, pre-retirement unemployment support). The activities of the Minister of Health, Social and Family Affairs are focussed on the fulfilment of the health policy, social policy and family policy tasks of the Government. In this work the Minister manages, coordinates and organises the health and social care system, the scientific and research activities in the sector, health and pension policy tasks relating to social insurance (in cooperation with the Minister of Finance) and also manages the National Health Insurance Fund and the National Pension Insurance General Directorate, as well as performs all tasks related to them, established by law. The Minister sets out the public hygiene and public health tasks, and is in charge of the public health programme aiming at the prevention of diseases, and all other tasks relating to health promotion, he controls the National Public Health and Medical Officer's Service, the agencies of health care with national competence, national institutes, health services provided in higher education institutions, health improvement research activities, and the Office for Authorisation and Administrative Procedures of the Ministry. The Minister also operates the Social Policy Council, the National Health Council, the National Disability Council, and he exercises regulatory supervision over the Hungarian Medical Association and Hungarian Chamber of Pharmacists. In order to fulfil his social policy and family policy tasks, the Minister defines tasks related to social care, child protection, and ensuring equal opportunities for disabled individuals, develops the system of social institutional care and services and identifies development trends for them, and also elaborates a system of family benefits and child raising support.

National Public Health and Medical Officer's Service

The National Public Health and Medical Officer's Service, operating as a public administration agency, performs mostly state tasks and implements a unified health administration system, with the following responsibilities: public health and epidemiology, regulatory licensing; sector neutral professional supervision; organisation, monitoring and control of prevention and health improvement (health protection, health education, health promotion). The NPHMOS has enforcement authority in the entire territory of the country concerning all natural and legal entities, as well as companies without legal entity (with the exception of armed forces and law enforcement agencies, but not the penal institutions, however, it has the right to perform sanitary inspections in these institutions, too).

National Health Council

The National Health Council is an organisation responsible for maintaining the continuity of long-term health policy and enforcing the rights of users of health and social services. The Council is a body involved in the development of the Government's health policy and decision making relating to the policy, by making initiatives and proposals, reviewing documents and giving advice, and analysing and evaluating the process of implementation of decisions. It has a very important role in identifying health improvement priorities, in which a professional consensus must be achieved.



Medical Research Council

The Medical Research Council (by the Hungarian abbreviation: ETT) is a proposal making reviewing, consultation and decision preparation body of the Minister. Upon the initiative of the Minister or members of the Council it takes a position on health policy, medical, pharmaceutical, scientific and any other health issues; it coordinates research activities falling under the responsibility of the Government, more specifically the Ministry, and makes proposals for the priorities of Hungarian and international research, assisting the transposition of research results into Hungarian health care practice. The Council also makes proposals for the design, implementation, documentation and control of clinical trials and biomedical research on human beings ensuring that they satisfy international ethical and scientific quality requirements, and monitors the implementation of such activities; the Council issues an opinion on scientifically founded research activities, and reviews and assesses the establishment of new regional research ethical committees, coordinating and promoting their standard operation.

Professional associations ('Chambers of healthcare professionals')

The two professional groups of the health care system, physicians and dental surgeons (hereinafter: physicians), and pharmacists, have had their professional self-government based on mandatory membership since 1994. The responsibilities of the Hungarian Chamber of Physicians and Hungarian Chamber of Pharmacists include individual management of professional matters through directly elected bodies and officials, within the framework defined by legislation, definition and representation of professional ethical, economic and social interests, and contribution of the formulation of health policy, and improvement of the provision of health and pharmaceutical care of the population in accordance with their importance in society.

Chambers are public bodies with public responsibilities, for which they are eligible for state subsidy, established by the act on the budget. Membership in the chamber is mandatory. In Hungary only members of the chamber may be engaged in activities requiring a physician's or pharmacist's degree.

On 4 March 2004 the founding general assembly of delegates officially created the chamber of nurses and allied health personnel, which is the professional interest representation and self-government body of the nursing and allied health personnel. In Hungary only those individuals may be engaged in the pursuit of activities requiring special qualifications in nursing and allied health in preventive-curative services who are members of the Hungarian Chamber of Nurses and Allied Health Personnel.

Medical specialty colleges

The medical specialty colleges are the highest level of proposal making and reviewing bodies of the specific medical disciplines, operated by the Hungarian Medical Association and Chambers of Pharmacists, but their operating expenses are covered by the Ministry. The Minister is assisted by 37 medical and 3 pharmaceutical specialty colleges. Apart from the medical and pharmaceutical colleges two groups of nursing and allied health personnel, i.e. nurses and health visitors, have their own specialty colleges.

The specialty colleges elaborate, regularly review and publish professional recommendations, guidelines and methodological letters in their special field, and form a position on the technical requirements and quality certification, while medical sections can also take a standpoint on minimum professional requirements of health service providers. The colleges have a very wide competence of expressing their opinion.



The health care delivery system and its ownership relations

Primary health care

In 1992 the district general practitioner's system was replaced with the family practitioner's service, with two main objectives. One of the objectives was the change the relationship between the physician and patient with the introduction of the option to choose the family practitioner freely, and linking the remuneration of family practitioner to the number of patients on their lists. From 1992 residents of other districts could also apply into the practice of a particular family practitioner, while a patient living in the district of a family practitioner may choose the family practitioner of another district too. As a result of this change, family practitioners have to compete for patients and for retaining their patients, and trust and satisfaction of patients with medical activities have become more and more important. Although free selection of the family practitioner can practically not take place in sparsely inhabited rural areas, the impact for the majority of the country's population was clearly positive. The other main objective was to make family practitioners responsible for what is known as gatekeeper functions, as they became the first meeting point between the patient and the health care system, providing as much definitive care as possible, enabling family practitioners (in agreement with the patient) to decide on the use of the specialist services, thus making patient pathways more rational. For the time being the family practitioners' system cannot effectively fulfil its gatekeeper functions. Practices which have joined the managed health care model experiment are exceptions from this general rule (see below).

Social insurance funds and their managers

In Hungary social insurance - consisting of health and pension insurance – was part of the central budget until 1988. On 1 January 1989, a Social Insurance Fund was established separately from the central budget, together with its manager, the National Social Insurance Fund Administration. In 1993 the Social Insurance Fund split into Pension Insurance Fund and Health Insurance Fund and the National Social Insurance Fund Administration was divided into National Pension Insurance General Directorate and National Health Insurance Fund Administration. The Pension Insurance Fund and Health Insurance Fund are supervised by the Government, and the National Pension Insurance General Directorate and National Health Insurance Fund Administration are managed by the Government through the Minister of Health, Social and Family Affairs (line minister).

Managed care pilot program

The health reform aims at the improvement of primary health care to a considerable extent. One of the potential ways to do so is tested within the framework of the managed care model experiment (Hungarian abbreviation: IBM). The objective of IBM is to provide care of a higher standard with more effective use of available resources. The model experiment started in 1999 on the basis of a Parliament decision adopted at the end of 1998, stating that the National Health Insurance Fund may enter into financing contracts, for maximum 200,000 population, with health care providers (managers of care), which agree to provide the full range of health services to the population concerned free of charge or, against co-payment in the statutory health insurance system, and to organise services that are not provided by them. In 2001 the limit number was extended to 500,000. In 2002, 7 care managers served on average 476,053 individuals, with 298 family practitioner practices participating in the pilot. In 2002, in total HUF 2,579.4 million savings were paid out to the care managers, of which HUF 1,949.5 million was paid out from the curative-preventive



fund. On average savings amounted to 10%.

Seeing the results, the limit was increased to 1 million population in 2003, and to 2 million population in 2004.

Outpatient care

The middle level of the health care system is outpatient specialist care. It has two types: general and more specialised outpatient care. General outpatient care must be provided for patients near their place of residence, so that they can have access to it without endangering their health, and using public transport. In the framework of general outpatient care the patient, upon family practitioner referral (or referral by another physician providing continuing care to the patient), or upon patient self-referral, receives single or occasional specialist health care, involving continuous specialist care in the case of chronic diseases not requiring inpatient care. Special outpatient care is a health service organised for the treatment of diseases, that require special expertise or special financial, material and professional skills (special diagnostic background).

One of the most important objectives of the health reform is to reduce the flow of patients to hospitals through definitive services provided in primary care, and specialist outpatient care. However, the increase of performance of outpatient care has not reduced the use of inpatient care, which cannot be explained with changes in the age composition of the population, with the reasons being in the special features of the financing system. Not only hospitals operate ambulatory units, but facilities qualifying as outpatient institutions can also provide inpatient care services, or one-day surgery interventions.

Home care, which involves skilled nursing care by the physician's order in the patient's home or place of residence, has been financed by the National Health Insurance Fund since 1996, and it has generally spread since 1998-99. The health policy objective of its development is to replace much more expensive hospital care.

Inpatient care

In Hungary there are three levels of inpatient care. The lowest level of hospital care includes municipal hospitals with basic departments, available for everyone within a 25-30 km range from their place of residence. The next level consists of county hospitals which, together with several Budapest hospitals, operate as regional centres for some disciplines. The national institutes and university clinical departments have both regional and national competences. The national institutes of health are responsible for curative, methodology and health policy tasks. The national medical institutes and university clinical departments are tertiary care facilities in their special areas.

The most important structural problem of the Hungarian health care system is its hospital centred structure: very often and without any specific reason, care often takes places at the highest and most costly level of the whole system instead of primary health care and/or outpatient care, as if bypassing them. Apart from their costly nature, the hospitals' uneven population geographic location is also a source of problems. The most frequently, but not exclusively, mentioned problem is the concentration of hospital capacities in Budapest: nearly 40% of all hospital beds are situated in Budapest, with its 2-million population, which is less than one-fifth of the total population of the country. The absorbing capacity of Budapest and the fact that national tertiary-care inpatient institutions are situated in Budapest explain the high volume of hospital beds exceeding the proportion of population, but the figures are definitely excessive.



Inpatient specialist care institutions: owners and capacities

Hospitals are primarily owned by local governments, and secondly by the state, on behalf of which the Ministry exercises the ownership right over university clinical departments and national institutes. In Hungary a large number of hospitals are run by churches, foundations and private owners, although the bed volume in such hospitals is low.

In a European comparison, Hungary has relatively few but large hospitals, with an average number of 458 beds per hospital. In the 1960s and 1970s the level of development of the health system was measured with the number of hospital beds, in addition to the doctor/population ratio, both in the western and eastern parts of the world. However, in the 1980s it was recognised in the west but the number of beds is higher than the required number, and the surplus capacity only increased expenditure, therefore they began to reduce the number of hospital beds. Hungary started to follow the same trend only after the change of the political system, in the middle of the 1990s. Although one-fifth of the hospital beds have disappeared, the number of hospital beds is still higher than in several EU Member States (e.g. Austria, Germany).

Since the middle of the 1990s there was a staff reduction parallel with the reduction of the number of beds in inpatient care, which stopped in 2001-2002, followed by even a moderate increase. It was related to wage increases in 2002, which made it easier to fill part of the vacant jobs.

Ambulance service, patient transportation

According to the Health Act the state is responsible for providing and organising the conditions required for safe, standard and coordinated operation of an ambulance service, which is a task performed by the National Ambulance Service, which is a state task (Hungarian abbreviation: OMSZ) in the entire territory of the country. Beside OMSZ private organisations are active only in the transportation of patients for the time being. Apart from rescue activities and transportation of patients, OMSZ is also responsible for oxyology training (emergency medical care), national supervision of first aid, participation in responding to natural disasters and mass accidents. The National Ambulance Service is supervised by the Ministry. According to the norms of the European Union the ambulance services of Member States must be capable of reaching any point of their country within 15 minutes. This requirement is met on 90% of the territory of the EU, and on 78% of the territory of Hungary.

Provision of medicinal products and medical appliances

In 1990, medicinal products were supplied in Hungary by 1,449 state owned public retail pharmacies and 30 private retail pharmacies. As a result of liberalisation the number of market actors multiplied in a short time, and with the privatisation of wholesale pharmacy supply centres state and local government ownership finally disappeared. The second half of 1990s was characterised with concentration and market cleansing, and after the turn of the Millennium the wholesale of medicinal products is dominated by only a few key companies. State-owned pharmacies were privatised and, together with newly established pharmacies, their number stabilised around two thousand. In line with continental traditions, the operation of public retail pharmacies is based on personal rights, and the pharmacies can only be owned by pharmacists operating the pharmacy.

The number of registered medicinal products increased from 1,620 at the end of 1989 to 4,924 by the end of 2002. The number of medicinal products is higher than 8,000, and together with the homeopathic products the total number of Hungarian medicinal products is close to 20,000. Despite the significant



increase, the choice is still behind the choice offered in developed countries, although all active substances required for medical treatment are available.

The market of medicinal products is strictly regulated even under the conditions of a market economy, following the practice of developed countries. The law states that medicinal products can only be sold by public retail pharmacies, and legal regulations determined retail price, and retail and wholesale margin, but the ex-manufacturer's price of medicinal products are liberated. (The relevant legislation has been in effect since 1997 and 1999.) The price margin system is digressive: the more expensive a medical drug, the smaller the margin.

Pharmaceutical reimbursements represent the second largest item in the budget of the health care system (after inpatient care), for whose containment both the Ministry of Health and Ministry of Finance take serious efforts. Despite the efforts the nominal pharmaceutical expenses of the social insurance system increased five times during the last 10 years, while the co-payment by the population grew more than ten times in nominal terms. With the annual 6-8% increase of the pharmaceutical market seen all over the world, Hungary was characterised by an even greater expansion of the market because of the otherwise (at least partially) necessary increase of the number of medicinal products, and by the fact that drug treatment shifted more and more to new (generally more costly) products.

The pharmaceutical expenses of the National Health Insurance Fund have increased significantly in real terms since 2001. However, the revenues of pharmaceutical producers continuously increased, and in 2003 they increased their revenues by 20% in terms of drugs covered by the social insurance scheme. The corresponding figure in the EU Member States is 5-8%. In addition, the increase of the price of over-the-counter medicinal products, which is not influenced by the state, also generated a considerable amount of revenue for manufacturers, which was significantly above inflation both in 2002 and 2003. In Hungary the rate of pharmaceutical expenditure is 30.7% from the total health expenditure, while, according to WHO data, the respective rate is 14.3% in Germany, 15.5% in Austria, 21% in France, and it is only 24.5% even in the Czech Republic. Only Slovakia spent more than Hungary.

According to WHO data, a Hungarian individual spends USD 280 on medicinal products at purchasing power parity, while in the wealthier Netherlands an individual spends USD 266, in Denmark USD 223, in the UK USD 240, and in the Czech Republic USD 242. Pharmaceutical expenditures keep increasing, but the increase of drug reimbursement cannot be tolerated. It can no longer be maintained that we spent as much on drug reimbursement as much as on active inpatient care throughout the whole year. During the last two years, but even before there, was an unbelievable dynamic increase in the pharmaceutical market without any professional reasons. While this increase is 6-8% in EU Member States annually, it is 24-26% in Hungary. This difference cannot be explained with any professional reasons. The Hungarian pharmaceutical market prices contain a huge reserve for drug promotion, and we definitely would like to put a stop to that.

The 3-year agreement concluded in 2001 did not prevent the increase of pharmaceutical prices, or the drastic increase of the pharmaceutical expenditures of the social insurance scheme. It allowed for an automatic price increase for all products, irrespective of word market price changes. It allowed 20% higher prices for manufacturers in the case of products that were newly put on the market. Consequently, it was clearly unfavourable for contribution payers. In 2002 drug prices would have grown up by 6.3% according to the agreement, which would have been much higher than the rate of inflation, but the Government, which entered into office did not allow the manufacturers the promised price increase, therefore in 2003 only 3.4% increase in the price of medicinal products for the population took place.

Manufacturers reacted to the measures reducing the price increases by boosting sales promotions, aggressive promotion, significant increase of advertisements, influencing the prescription practices of physicians, i.e. shifting medicinal product consumption towards more and more expensive products.



The increase of the population's drug expenditures and the dynamic increase of the expenses of the Health Insurance Fund on drug reimbursement forced the Government to introduce effective and strict measures. Upon the initiative of the Ministry, the Government decided to "freeze" drug prices at a fifteen per cent lower level in the middle of March 2004. As of 1 April, the co-payment for about 10,000 products of the approximately 12,000 medicinal products marketed in Hungary decreased by 10-15%. As a result of this measure, 42 manufacturers signed agreements with the National Health Insurance Fund to pay 15% of their turnover into the Health Insurance Fund. In the case of manufacturers – approximately 120 – which refused to enter into an agreement with the Government, the Government exercised its option provided in the Act on Prices, and froze the ex-manufacturer's prices at 85% of the price prevailing on 31 March for 180 days from 1 April. Consequently, the co-payment for medicinal products has dropped by 10-15%.

Subsequently, the Government took appropriate steps in order to increase the safety of the provision of pharmaceutical care. It provides interest-free loan to pharmacies to compensate them for the depreciation of stock arising from the price decrease. It is in the interest of the Government to agree with pharmaceutical manufacturers as soon as possible in order to keep population drug expenditure under control in the future. The negotiations are in progress in that respect.

Healthcare Reform

Background

Healthcare reform in Hungary has been a relatively consistent process for the last 15 years, which has not followed the political changes that took place after the change of the political system.



In Hungary social insurance has a long tradition: Hungary was the second state after Germany which created an act on social insurance in 1891, based on the Bismarckian principles. It primarily introduced a multiple insurer differentiated sickness insurance system covering employees, involving practically two-thirds of the population. After World War II, the health system followed the Soviet pattern in accordance with the then prevailing political environment. There was almost full access in the new system, only a few self-employed persons were left out from it, who managed to avoid collectivisation and nationalisation. The final framework of the system was completed by 1972: the Health Act passed in 1972 set forth the need for universal, high quality and free health care system in keeping with the intentions of socialist health policy, and it was implemented in the Social Insurance Act passed in 1975. The health institutions were in decentralised state ownership (related to the 'council' system) and the financing channels also operated throughout the system.

The services were organised on the basis of progressive levels of care on a geographic principle, and its results included good primary health care and the development of a unique health visitors' (MCH nurses) system in Europe, the roots of which went back before the War. Good access, mandatory vaccinations and screening, as well as the decrease of social differences enabled the system to achieve very good results first



of all in the reduction of highly prevalent communicable diseases, primarily TBC. However, the bulk of care to the increasingly frequent chronic diseases kept creeping up in the hierarchy of progressive care. In contrast with all progressive principles starting in the 1970s, the system became more and more hospital-centred, it did not follow the demographic changes, and faced growing efficiency problems.

The funding of the institutions took place on a historical “basis”, irrespective of how many patients were treated or how they were treated. It was only possible to divert from the basis by assuming new additional tasks (e.g. new technology). A system of “obtaining by lobbying” (informal bargains) developed for these new tasks and extra funds. Health care workers (including physicians) received fixed salaries depending on seniority and position. The entire period was penetrated by the invisible and uncontrollable mixture of incentives of the gratitude money system.

It should also be noted that due to historical traditions, even the Soviet-based socialist health care system retained the institution of social insurance in Hungary. The responsibility of the unified social insurance scheme, formally supervised by workers through the national council of trade unions, was limited to the disbursement of financial benefits (pension, sickness benefit, disability pension, maternity benefits, family allowance).

Transformation during the change of the political system

The present institutional system of health care developed during the first government after the change of the political system. The councils of the old public administration system were replaced by local governments. Thus, the former council tasks (ownership, operation) were shifted to local governments. The regulatory, licensing, control, supervisory and public health tasks, together with the public hygiene and epidemiology, and enforcement authority were moved to the National and Medical Officer’s Service in 1991.

The social insurance reform continued too: In 1992 the pension and health insurance funds and their administration were separated. The philosophy of the system also changed: the statutory nature of social insurance for everybody was terminated formally, participation in the system was no longer obligatory for those living on capital income, and they could decide whether they would voluntarily join health insurance or not. In 1993, the supervision of the social insurance funds was taken over by self-governing bodies elected on the basis of trade union lists.

In 1992, people were allowed to choose a family practitioner to replace their former district GP assigned by the state; family practitioners were paid on the basis of their list size. In 1993, the former “base” financing was replaced with a payment system in which institutions received money on the basis of the performance reported. Although financing is clearly sector neutral, ownership relations are still dominated by state and local government ownership. Exceptions to this rule are areas whose development is rather capital intensive and the state was unable to provide appropriate development funds (e.g. expensive diagnostics, kidney dialysis, lythotripsy, etc.).

The act on voluntary health funds in 1993 was the last step in the development of the framework of the current system. This created an opportunity for community health protection and non-profit voluntary supplementary insurance, supported with a tax credit.

The necessary corrections of steps took place between 1994 and 1998. Major pieces of legislation were adopted, that created the frameworks for previous changes, and set out directions for further



development: the new Health Act and new acts regulating the social insurance system. An important result of this period is the reconstruction of universal insurance obligation in social insurance, and start of quality regulation and quality policy. The Health Act required the operation of quality systems, and included the issue of patient rights among the responsibilities of the health care system. A patient rights advocacy system was developed, and the minimum professional requirements were also issued. An act regulating data handling in the health care was also passed. Another important change in the electoral cycle included the appearance of the capacity regulation instrument with the act on obligation to provide health care and on area-based financing norms. Professional preparations began for the Hungarian adaptation of the GP fundholding and Managed Care systems.

Between 1998 and 2002, the “right of practice ” concept was introduced in primary health care, which turned the right of operation of a practice into an asset type right i.e. a marketable right subject to certain professional conditions, for parties working in primary health care. The managed care pilot project started in 1999. The important event of this electoral cycle was the launch of the public health programme and the adoption of the first institutional act. The first version of the institutional act provided for selected issues of institutional operation and legal status of health employees in one act, and required a mandatory non-profit operating model for hospitals.

Reforms in the current government cycle

A distinct promise of the elections in 2002, as well as of the government programme concerned a commitment to bring about a “welfare turn”, including the “Decade of Health” programme. The two main elements of the programme are the expanded continuation of the public health programme and the programme of consolidation– modernisation of the healthcare system. The series of measures started with a stabilisation programme containing 50% wage increase, which was also intended to settle hospital debts. The Parliament resolution on the public health programme was carried by an almost 100% parliamentary majority. New acts regulate the operation of health institutions and health workers’ conditions of work. Although the amendments allow hospitals to operate for profit, but it prohibits the sale of hospitals: for 5 years investors can only reach the maximum 50% stake with capital increase, but not with buyout. The individual conditions of work in the health sector and issues of overtime work are regulated in a separate act.

A new phase of the reform is based on the extension of managed health care experiments and regional care organisation and planning. The objective is to improve the efficiency of the system, and to bring fund allocation decisions closer to the patient. The new system involves decentralisation of certain social insurance tasks and brings the values and interests of health policy in balance with the extension of costs sensitivity. Regional Health Councils shall be formed, which prepare regional health development plans. The reform of emergency health services is an important element of the regional service organisation based on the principle of progressive care, and is based on a unified fixed entry point, and relies on emergency care departments.

The health reform aims at creating a healthcare delivery system that ensures more equitable access than at present, operates in an up-to-date structure, is of controllable quality acceptable for patients and is able to ensure competitive and sustainable development for this country as an EU Member State. This requires the organisation of services providing high quality care for the insured. The modern service system could be based on the extension of the managed care system replacing the currently running managed care



pilot, and relying on all elements and results of the reform processes to date. The basic principle of the model is to have patient care based on funds allocated from the health insurance according to the number of population, and adjusted to needs. Care managers have direct interests in “purchasing” the necessary and adequate quality health services for patients at the right place and time. It is the interest of both the patient and the social insurance scheme.

Managed patient care may significantly increase the quality of the service delivery system, improve efficiency of the services and may promote the development of a system adjusted to population needs and requirements. The objective of the transformation of the financing system is to allocate the funds to wherever they are actually needed, and are used most effectively.

As a result of the health reform citizens obtain adequate level health services in an early stage of their diseases, which improves the chance of their recovery. The standards of care and the conditions of service delivery may improve and, parallel with that, the number of unnecessary parallel examinations may decrease. Targeted drug treatment may reduce drug consumption. As a result of the reform, efficiency and transparency of public expenditure on health care will improve and the available public funds may lead to the greatest possible health gains on the level of society as a whole, in other words, the population’s health status may improve.

From 2004, the regulation of voluntary supplementary health funds has changed. Health savings accounts were introduced for the purpose of making private health expenditures transparent, for encouraging the licit purchasing of services, and invigorating competition between service providers. Preparations have been made to introduce long-term care insurance (accounts).

Europe Plan – building a modern republic

The Europe Plan, aimed at the modernisation of the country in the form of a development plan for the whole nation is based on funds of Hungary and the European Union. As a result of the accession HUF 1,350 billion will be available for the country.

In his speech made in April 2004, Prime Minister Péter Medgyessy described the period starting with the accession as the period of chance and action. He urged for changes and promised changes for the purpose of creating a strong, modern and European Hungary. The government in half term of its mandate has confirmed that it intends to modernise health care, and wishes to reorganise health services, because the demographic indicators and improvement of the population’s health status call for urgent intervention. The objective is to turn the modern European Hungary into regional service centre in this area, for which an indispensable condition is a health care system of European standards.

Within the framework of the Europe Plan and in order to modernise the health care system, 25 ambulance stations will be reconstructed and 150 new ambulance cars will be put into circulation in 2003–2004. The Ministry of Health, Social and Family Affairs issued an open public procurement tender for the reconstruction of 33 ambulance stations. The modernisation of the majority of them was completed by 31 December 2003.

Another programme was launched to replace medical devices involving a total amount of HUF 10-15 billion, of which HUF 2 billion is state support. The Ministry of Health, Social and Family Affairs issued a restricted tender in 2003 for modern imaging diagnostic equipment in the amount of HUF 10 billion



forint, and for the procurement of anaesthesiology and intensive care equipment in the amount of HUF 5 billion.

In 2004, reconstruction of 12 local government-owned hospitals started, involving more than HUF 20 billion state support.

Health is an asset and investment: The Decade of Health

On the basis of the unfavourable public health processes of the last few decades, the government assigns priority importance to the improvement of the public health situation and recognises the population's expectation to gradually close the gap between life expectancy at birth of Hungarians and the average of the EU Member States. Any tangible improvement in the health status of people and in the healthcare delivery system may only be achieved over a longer period, covering several electoral cycles. Maintaining and promotion health cannot be regarded as expenditure only, or an action driven by ethical considerations, but the implementation of the Programme is a productive investment, and a prerequisite for the social and economic development of the country.

During the design of the 'Johan Béla' National Programme of the Decade of Health, experts took into account all experiences which were related to former developments for public health purposes.

The Programme's implementation is based on the following four principles:

- Reduction of inequalities and creation of opportunities. In the case of each major decision and social process, their impact on health and equal opportunities need to be taken into account. The available funds must be distributed in a way that, in addition to wide and general improvement of health conditions, also promotes mainstreaming of groups falling behind.
- Community participation and democracy. The basis of this principle is participation of legitimate representatives of local communities, local governments in health development and involvement of NGOs, local, regional and national social initiatives in the activities performed for health. Local governments have the majority of personal, material and financial assets which are required for effective local health development. The government contributes to this work with targeted financial support and other methodology and technical assistance provided through budgetary institutions. A long development period is required before the local government system is capable of effective health development at local and regional levels, but actions pointing in this direction can no longer be delayed.
- Effective intersectoral co-operation. Co-operation is aimed at a favourable influence on the social and economic determinants of health. Co-operation takes place in modern public health at several levels. With the accession to the European Union, the importance of international co-ordination has increased significantly. Intersectoral co-operation is indispensable at national, regional and local levels. Local intersectoral co-operation is an effective tool for influencing health determinants. At national level, the establishment of organisational structures and operational models required for co-operation is a primary task. The Interdepartmental Public Health Committee has been established recently. The activities of the Committee are based on bilateral or multilateral co-operation between ministries, setting of common objectives, and supporting intersectoral co-operation. Intersectoral co-operation must cover individual ministries, local governments, public institutions, private sector, civil sector and media. There is a need for continuous monitoring of the effects of individual political decisions, social and economic changes on the health status of the population, with special consideration to the disparities affecting certain population groups.



- Sustainability, long-term thinking and planning. Sustainability, maintenance of the results of the programme, and institutionalisation have been outstanding objectives since the designing phase. In this context, the development of public health and health care resources (personnel, institutional, financing) represent a very important part of the Programme.

The Programme's estimated impacts on the society in ten years' time:

- the average life expectancy at birth will increase to at least 70 years for males and at least 78 years for females,
- the number of healthy years of life will increase, and the quality of life of the population will improve,
- inequalities in health of the population will be reduced,
- there will be an opportunity for disadvantaged groups of the society to catch up with the rest of the population in health and social welfare terms,
- healthy lifestyles will become an example for the whole society, and the set of values and everyday habits of the population will change accordingly,
- intersectoral co-operation shall evolve and become regular at all levels in the interest of health,
- community actions will be strengthened, and the role of the civil sector and local society in health development shall increase.

Professional impacts in terms of health in ten years' time:

- premature and preventable mortality as well as the early occurrence of chronic non-communicable diseases will be reduced,
- the need for preventive-curative care will diminish, or shifted towards elderly care, in disease categories targeted by the Programme,
- geographic and social disparities in access to health services will be reduced,
- preventive health services will develop and become more varied,
- the quality and cost efficiency of health care will improve,
- the public health institutional system will change in response to modern requirements, and will be adjusted to EU standards,
- research and training related to public health will develop.

Long-term economic effects:

- the Programme is an investment into human resources development, and its cascading favourable effects will be reflected in the sustainable growth of the economy,
- the quality, efficiency and competitiveness of human resources will improve,
- within the framework of the healthcare reform, the programme will promote better-quality and more cost-effective operation of the sector,
- as a result of intersectoral co-operation, it will mobilise new resources and reserves,
- it will expand the market of health-promoting products and services,
- the Programme will significantly contribute to the improvement of the population's living standards.



The Programme intends to make progress in four areas. On the political level in the first place, it intends to devote outstanding attention to

- the issues of youth,
- the problems of old age,
- equal opportunities, and
- establishment of an environment supporting health in the various areas of life.

An important objective is to change lifestyles, and to implement primary prevention in society. In this aspect, the key priorities are

- reduction of smoking,
- alcohol and drug prevention,
- dissemination of healthy nutrition habits,
- promotion of physical exercise, and
- development of a healthy physical environment.

Steps need to be taken to prevent preventable deaths, diseases and disabilities. In this aspect, the priorities are the following:

- reduction of mortality due to coronary heart disease and cerebrovascular disease,
- putting a stop and reversing the increase of mortality due to malignant neoplasms,
- strengthening of mental health promotion,
- reduction of locomotor diseases and the ensuing disabilities,
- prevention of AIDS and other sexually transmitted infections, and
- increase of public health safety, and rapid response capabilities.

In relation to the priorities of the Programme, it is necessary to develop the healthcare and public health institutions too, in order to improve the population's health status to the required extent by:

- introducing screenings of outstanding public health importance,
- developing the healthcare delivery system, with special priority assigned to the development of primary health care, and intensifying prevention activities and improving their conditions at the PHC level,
- developing resources in a concentrated manner in the diversified world of public health, so that it can face challenges in terms of experts, as well as material and organisational resources,
- developing a monitoring system with which the Programme can be monitored continuously and the necessary corrections can be made.

The successful implementation of the Programme is a key component of the growing welfare of the population, long-term creation of opportunities, and sustainable economic growth of the country.

'Johan Béla' National Programme for the Decade of Health – 2004

Improving the population's health status and welfare is the ultimate goal of economic and social development, yet it is a well recognised fact that it is also one of the pre-requisites of social and economic development. In this process, the reduction of disparities in health status of the population is very important. Health conditions cannot be improved without well-founded international, national or regional political strategies.

Endorsed by a Parliamentary resolution in April 2003, the 'Johan Béla' National Programme of the Decade of Health sets out its tasks in order to improve the unfavourable public health conditions. As a result,



in ten years' time, life expectancy at birth must be three years longer for both men and women. The two main established ways to do that, i.e., protection of health of individual citizens and the reduction of the frequency of major diseases, injuries and causes of death will continue to remain parts of our activities in the future too.

The most important tasks of this program for 2004, which will be overarching this government cycle, are the following:

Development of a social environment conducive to health

Equal opportunities and protection and respect of minorities are among the most important guiding principles of the European Union. The same principles are also governing principles in health. The "Equal opportunities for health" sub-programme launches its activities in accordance with the other sub-programmes, devoting a lot of attention to the improvement of health status of the Roma population, disabled people and the homeless, and development of a harmonic relationship between the health care staff and patients.

A healthy start in life and health improvement of children and young people are especially important. Preparation for a healthy life represents an investment into the future, and promises a healthier Hungary on the long run. Therefore, support to the programmes of Healthy Youth is an outstanding priority in 2004. There are two main objectives:

- the possibility for healthy life must be provided for everyone from conception,
- in addition to the family, schools should be the most important setting for health improvement.

On the basis of the resolution of the Interdepartmental Public Health Committee, support to health improvement in schools shall be of outstanding importance. In addition to the health development activities taking place in public education institutions, a lot of attention shall be devoted to local community and local government health development programmes, financed on the basis of grant applications, and health development, health protection and family planning initiatives of disadvantaged social groups.

Healthy lifestyles programme, mitigation of risk factors of human health

Learning healthy lifestyles and developing health-conscious behaviour are a task for the whole society. The Interdepartmental Public Health Committee puts these tasks into a wider social context, and expects financing from other ministries too. It is a clearly health policy objective to allocate resources not only in the health sector budget, but the implementation of the programme being a government objective, all ministries should feel ownership for the programme and assess the health impacts of all their measures.

Tobacco control

According to the data of the Central Statistical Office, 28,000 people die from various diseases caused by smoking, primarily from cardiovascular diseases and lung cancer in Hungary. Unfortunately, Hungary is in the "prominent" sixth position in the world concerning the number of cigarettes smoked (20 billion cigarettes a year, with smokers spending approximately HUF 300 billion a year). The increase of cases of lung cancer among women is especially frightening, coupled with the fact that smoking is becoming more and more popular among young people too.



The Hungarian government has also signed the Framework Convention on Tobacco Control, adopted by the World Health Organisation. The Framework Convention creates an instrument that can provide guidelines for parties to the Convention to reduce diseases and deaths caused by smoking. The annual tasks focus on activities arising from the signature of the Framework Convention on Tobacco Control and amendments of Hungarian legislation (the system of institutions of smoking cessation, youths programmes, etc.), as well as joining the various actions of the European Union.

Alcohol and drug prevention

The priorities of the year in the area of alcohol prevention are the following: development of primary health care in this respect, introduction of pilot programmes for early initiation of treatment for alcoholics based on workplaces, and innovative methods of early treatment. Alcohol and drug prevention education will start in higher education institutions. Preventive programmes aiming at youth protection are extremely important. In order to fulfil the obligations arising from the accession to the EU, in the area of drug prevention, a National Drug Information Focal Point will be established in Hungary as part of the European Information Network on Drugs and Drug Addiction (REITOX) of the European Union.

Environment and health

It is well known that environment has a significant impact on our health and life expectancy. As the Hungarian population's health status is very bad compared to neighbouring countries, as well as to other European countries, we have to make definite steps to prevent the deterioration of the situation. It is absolutely necessary to support environmental health status analyses and action programmes which take into account new requirements arising from the EU accession, and develop environmental and health research. The key research subjects are the following: relationship between the quality of air and respiratory diseases, impacts of potable water pollutants and their components, impacts of toxic and carcinogenic chemicals, criteria of qualification of wastes.

Healthy nutrition

In Hungary, inappropriate dietary habits and little physical exercise contribute significantly to the unfavourable health status of the population, and the consequential high mortality. Most of these diseases can be prevented with healthy nutrition and a physically active lifestyle. The recommendations of health promoting and disease preventing diets and lifestyles are simple, compliance with them does not require major efforts, or extra expenses, the only thing we should do is to learn and apply the principles in our everyday life.

In 2004, we shall focus on children in evolving healthy dietary habits for the population.

Prevention of avoidable mortality and morbidity

The priorities of the National Programme setting the framework for professional tasks in 2004 include the reduction of premature and avoidable deaths, and prevention of diseases and disabilities. The main tasks for this year include support of secondary prevention in primary health care, especially the hypertension programme, development of oncological alertness in primary health care, continuation of mental health activities (especially in order to prevent suicides) and support of mental crisis intervention activities.



We shall also continue the prevention programme related to locomotor diseases, including the screening and physical therapy-remedial gymnastics programmes for children and youth, as well as pilot programmes aimed at the prevention of osteoporosis over the age of 50 years.

The screening and continuing care activities in relation to hypertension and diabetes are of great importance. Timely diagnosis and appropriate continuing care of these diseases improve the quality of life of patients and reduce related mortality.

AIDS prevention

In Hungary, the number of people infected by HIV is low in international comparison, and it is also very important to avoid negative changes similar to the ones taking place in other countries of Central and Eastern Europe. In order to achieve this objective, the health administration provides funds for anonymous AIDS screening, information provision programmes in schools and screening examinations of specific high-risk target groups (e.g. IV drug users).

Development of the healthcare and public health institutions in order to improve health status

One of the requirements in achieving the above objective is to have an appropriate pool of professionals with the necessary qualifications and expertise in public health and other related sciences, therefore it is very important to support programmes of education and continuing education in public health.

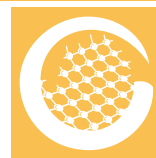
The monitoring sub-programme, measuring progress and efficiency, regular monitoring of efficiency indicators, and their publication after the required analyses are important parts of our activities.

Public health screening

Organised mammography screening started among the population in the framework of the then 'For a Healthy Nation' Public Health Programme in December 2001. In 2002, the public health screening programme was integrated into the 'Johan Béla' National Programme of the Decade of Health; the mammography screening activities have continued. At the moment, 39 screening sites are active, and three more will soon be included in coverage.

Development of institutions promoting the national breast cancer screening activities, started in 2001, and continuation of the national cervical cancer screening tests, introduced in 2003, description of the programmes to the profession as well as the population at large will continue to be of great importance in 2004 too. Special attention shall be devoted to increasing participation in the screening tests. General education among disadvantaged population groups and their active involvement into screening are also in the focus of attention.

Screening for colon cancer will also be introduced gradually in Hungary.



SOCIAL SERVICES SYSTEM

Social inequalities

The Hungarian analyses indicate that before the change of the political system, the place of the individual in the system of inequalities was related mostly to cultural factors (knowledge, qualifications, education) but after the change of the political system the impact of income factors increased too (although the dominant role of the cultural capital continued to exist).

One of the important consequences of social inequality is poverty, the elimination or at least mitigation of which is an important task of social policy, primarily implemented through the social services system.

In general, poverty research in Hungary is based on measuring poverty in income, in which the advantage is that calculations can be based on the per capita income in a household, which can be measured relatively well. However, the disadvantage is that it is only a one-dimensional aspect, i.e., it can only take into account poverty factors other than income to a limited extent. Hungarian research activities indicate that after the change of the political system the proportion of poor people has increased significantly, but during the latest years this proportion has not increased, in fact, it has stabilised.

The most important risk factors of poverty are disadvantages in education, living in small settlements, increase in the number of children in a household, being part of the Roma ethnic minority, unemployment, and living in the Northern and Eastern regions of the country;

Welfare support (family allowance, pension, unemployment benefit and aid) has a very important role in the mitigation of poverty.

Ensuing also from risk factors, low educational level increases the probability of unemployment, and those who live in households led by unemployed individuals have a four times higher chance to be included in the lowest income quintile. Surveys indicate that those who live in farms or villages have twice the average chances to become poor, which means that not only lack of schooling, lack of information, but also the geographical distance of potential work from home also significantly deteriorate their chances in the labour market. According to the surveys, each new child entails a 1.3-time increase of the probability of getting into the lowest income quintile, and in the case of single parents, every second member belongs to this category. Members of households led by pensioners have twice the average chances, and members of households led by Roma individuals have five times the average chances to be integrated into the lowest income quintile. According to research, 50% of children living in Roma families have a household without any active income earner. Naturally, the chance of poverty increases even more if risk factors cumulate, i.e., for example in villages with a high unemployment rate more than half of the Roma population have been excluded from the labour market. So these facts indicate that poverty is mainly the result of social inequalities.

Homeless people are in the worst situation among the poor. In addition to those who regularly spend their nights under the sky, homeless people also include individuals who regularly use the services of homeless facilities, and those who spend their lives in structures, which were not built for residential purposes, or huts on public areas, or in caves.

The social and economic transformation taking place since the change of the political system has also produced some homeless people even from members of middle classes. Not only employees of eliminated



companies, but also bankrupt entrepreneurs have become homeless. Homeless people are the biggest losers of social inequalities, poverty and economic transformation processes. Their poverty is the deepest even in the traditional sense of the concept, because they do not have any stable housing options, and they receive absolutely and relatively less than anybody else. They are at the bottom of the social pyramid in all aspects, and their position will remain the same for a long time, because if they do not have a home address, no aid can be disbursed for them and they cannot take employment either, i.e., they have much worse chances for breaking out than average individuals with poor income.

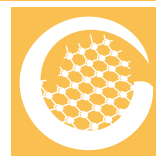
Welfare turn in social policy

One of the key objectives of the government programme is to achieve a so-called welfare turn. The implementation of this programme has started with the performance of income policy measures that have been delayed for a long time. The pay rise in the public sector, old-age pensions in the own right, surviving spouses' pensions and equity-based pensions, social income (including family allowance), various student welfare subsidies, and the preservation of their value in real terms, the return of tax on minimum wages, retention of housing type tax allowances based on children for those with a low income, the annuity programme of old landowners and other measures represent significant and durable results. However, the welfare turn does not only involve an outflow of income, but also a deliberately undertaken programme-type correction in the set of values reflected in the redistribution of income.

The objectives of the welfare turn are achieved primarily through the time-proportionate performance of the various tasks included in the work plan. Some major development actions have already been completed (for example, concerning services to the homeless) and some other important system innovations are also included in the plans (for example, development of so-called long-term care insurance). Such development is also assisted by programmes involving adjustments to the objectives of the European Union, such as the applicable parts of the National Development Plan and of the Joint Inclusion Memorandum (JIM).

However, during the recent period it became obvious that the success of a welfare turn, and welfare change of the political system absolutely needs fundamental changes in the operation of the social protection system. This involves objectives such as transparency and co-ordination of legislation, adjustment of operation of institutions to people's needs, professional standards in administration procedures, adherence to legislation, guarantee of democratic and quality control, a financing system adjusted to practical performance and quality of services and significant improvement in data management and information supply.

All these represent conditions and a framework for the implementation of the welfare policy involving equal requirements for the value and scope of services, the performance of which affects the efficiency of social protection a great deal. Other factors affecting the efficiency of social protection include income ratios, quality of services and targeted services. In our view, it is a current task to renew what might be called the civilisation dimension of the welfare system, because without this the impact of certain measures included in the individual programmes may be reduced and our social protection system could divert even more from real problems in the society. In fact, this involves legal, institutional and administrative changes, modernisation of the method of operation, financing and eligibility, harmonisation of specified conditions of really sector neutral partnership, a kind of reform of social mechanisms.



Legislation in social welfare

Act 3 of 1993 on social administration and social services sets forth comprehensive provisions on the rights of users of social institutional services. The act requires full and comprehensive respect for constitutional rights, and details the special rights of individual groups using the services, devoting special attention to the position of disabled individuals, psychiatric patients and homeless people. In order to uphold the rights of users of social services, an advocacy system will also be developed to represent the rights of social service care recipients in accordance with the requirements of the law.

Act 31 of 1997 on the protection of children and guardianship administration sets out an obligation to protect all rights of children subject to protective care. The act provides that children should be given assistance in learning and enforcing their rights with the involvement of a children's rights advocate.

The legal regulations specify the tasks of organisations providing the services as well as their employees to respect these rights.

Joint Inclusion Memorandum (JIM)

The EU has initiated co-operation with the accession countries in order to act against social exclusion jointly. The objective of the work was to enable Hungary to prepare for the use of an open co-ordination system related to social inclusion by the time of the accession.

In accordance with the recommendations of Accession Partnership, the Joint Inclusion Memorandum was prepared with the main responsibility of the Ministry of Health, Social and Family Affairs in accordance with the EU strategy against social exclusion and poverty, and the Nice objectives, and it was signed by the Hungarian Government and the European Commission on 18 December 2003.

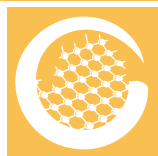
The memorandum lists the challenges that need to be managed in the efforts against poverty and social exclusion in accordance with the accepted EU objectives, and describes the main policy areas which can be used as the basis of joint evaluation in future.

The EU Joint Report on the memoranda of the accession countries will be completed in the first half of 2004 and, at the same time, national expert reports will evaluate the joint memorandum, followed by the National Action Plan later.

On the basis of the schedule prepared by the EU Commission, Hungary will also prepare a National Action Plan on Social Inclusion by the third quarter of 2004, the latest. This plan can bring considerable results in the labour market integration of inactive and disadvantaged people in the area of access to employment services and rights. Our ministry is responsible for the compilation of the National Action Plan, and co-ordination of the inter-departmental committee and interdisciplinary team drafting the plan.

Amendments of certain legal regulations on social welfare for law approximation purposes

Several legal regulations relate to the situation of socially disadvantaged people and families in need. Act 3 of 1993 on social administration and social services, in short the Social Act, is the most important piece of legislation in the area of social protection. Its key role is to define cash and in-kind benefits on a solidarity basis, as well as personal services, and regulate the relating administration system.



The Social Act has become a very important new legal regulation of the first ten years after the change of the political system, and has significantly contributed to making the severe social burden involved in the transition bearable. At the same time, as a result of accelerated changes, this act has by now become obsolete for many aspects (together with the relating pieces of legislation) and it cannot provide an adequate framework

for the management of new social problems, or prevent social exclusion without major amendments in the near future.

The Ministry of Health, Social and Family Affairs has launched a separate programme under the title 'Potential renewal of the Social Act and democratic and long-term development of social administration'. The abbreviated title of the programme – SZOLID Project – also expresses that its main objective is to create a new act of central importance regulating benefits and services provided on a solidarity basis.

The legal regulations concerning social security and labour market have several connections with the world of social services, but this project does not aim to develop amendments of borderline regulations. On the other hand, it is an objective of the project to co-ordinate with borderline reforms and, if necessary, to make recommendations for practical changes in other affected legal regulations too.

The work is not directly related to the measures of the welfare policy of the government, or changes in the degree of individual services, but it affects the operation and performance of the social protection system at several points, which may also involve some restructuring of benefits and services.

The objective of the SZOLID Project is to lay down the foundation of legal norms and institutions of a social welfare system after the closing of the 15 years of transition period following the change of the political system and after the EU accession.

Objectives of the new basic piece of legislation of solidarity:

- to allow for adequate protection of individuals and families against poverty, to define the system of social entitlements, and promote their recognition within the society, to provide adequate legal protection and social security for everybody who is in need of social care, and promote social integration,
- to ensure harmonisation of the legislation concerning social welfare, and eliminate unnecessary or parallel regulations,
- to ensure (or create) the legislative conditions, guarantees and predictability as well as accountability of services, and to regulate the executable requirements,
- to adjust to up-to-date EU and Hungarian norms,
- to ensure the conditions of multi-sectoral nature in the services,
- to be in line with the transformation processes of the public administration and local government system,
- to provide a long-term framework (for several decades) for social care, services, self-management and self-support and to provide an adequate legislative framework for the development of the social welfare system.

The social welfare system

In the Hungarian social system, services are provided by three main actors: the state, local governments and the civil or non-profit sector. The legislation is based on a constitutional authorisation, according to which the Republic of Hungary provides care for those who need it with extensive social measures, and



citizens have a right to social security, which right is enforced through social insurance, and partly through the system of social institutions.

According to the effective legislation, local governments provide the services which are defined for them by legislation, and which they undertake on the basis of a resolution of their assembly of local councillors. Service obligations (in a framework structure) are defined for local governments primarily in the Act on social administration and social services. These are partly cash and/or in-kind social benefits, and partly social services. According to legislation, the two main categories of social services include primary services and specialist services related to personal care. Benefits in cash and in kind, as well as social services are available on a means-tested basis, with the establishment of social need being defined by the per capita income of the household.

Benefits in cash and in kind may be provided in a regular or ad hoc form (certain types of aids can be provided in both ways). In the aid system, prevention of the total financial failure of the elderly (elderly annuity), alleviation of high housing expenses (for example, housing support), and prevention of total deterioration of health status (for example, medical indigence card), as well as reduction of the crises caused by unexpected fatal events (for example, funeral aid) are the most important factors.

According to the effective Social Act, cash benefits include elderly annuity, regular social aid, housing support, carer's allowance, temporary and funeral aid.

System of social services

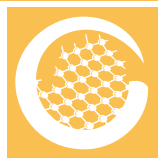
The system of social services includes benefits based on personal care. While cash and in kind benefits are primarily aimed at members of the population capable of working, the legislator has established a system of social services covering the nursing and care requirements of individuals who find it difficult to enter the labour market or cannot enter the labour market at all primarily because of their physiological or physical conditions, or individuals who already left the labour market, or those who are in a durably difficult financial situation (elderly people, disabled people, homeless, psychiatric patients and addicts). The system of social services is a lot more complicated than the system of cash and in kind benefits, because it distinguishes between

- by the system of the law, primary and specialist services, in which the latter category requires a special organisational framework,
- by the types of services,
- primary and day services for those who can be supported in their homes too,
- temporary and long-term institutional care for those who need institutional services,
- by the type of organisation of services,
- independent or complex (integrated) types of organisations.

Primary services

Primary services are aimed at those from the socially needy for whom residential care is not required, but may receive social support in their own homes or living environment. Such people include e.g. elderly, disabled people, psychiatric patients and addicts, who do not require long-term residential care on the basis of their conditions. The local government has to organise the primary care services within its own competence.

The users of family assistance services within the framework of primary care include families struggling with social and mental hygienic problems, and/or critical conditions. Family assistance is a free of charge



service, involving mainly information supply, consultation, administration assistance and involvement in conflict solution. Special assistance services may be organised for individuals who are subject to cash or in kind social aid (e.g. unemployed, people struggling with living problems), or, based on their health conditions, are also eligible for social services (e.g. disabled, psychiatric patients and addicts), providing that the

local government operates a separate institution for providing family assistance services. Such a special service could be e.g. counselling for young people.

A special type of primary care institution is the village manager's and, from 1 January 2003, farm manager's services. Since 1997, primary care tasks may be performed within the framework of village management services in villages with less than 500, subsequently 600 inhabitants or, within the framework of farm management services in suburban areas or other urban areas with 70-400 inhabitants, if other legal regulations also allow for it. These services are clearly aimed to provide services for small settlements in the framework of primary care.

Residential services

The objective of residential services is to provide personal care in residential institutions for individuals who require it on the basis on their age, health conditions or social situations, and cannot be kept in their own homes.

The first category of residential institutions include nursing homes and respite care institutions, which are open to individuals who satisfy the conditions defined above and their care cannot be organised in any other way.

Rehabilitation institutions try to develop or reconstruct the individual lifestyle of their residence through targeted therapeutical sessions. Stay in such types of institutions cannot be longer than five years, but it may be extended by maximum three years on one occasion. After this period of placement the institution will provide follow-up care to its patients for maximum two years with the involvement of an external service provider or external institutional spaces.

Disability – an issue for all of us

The primary objective is to provide equal access to quality services. In order to organise an effective service system for people with disabilities there is a need for local small and regional civil organisations which perform classical interest protection tasks as well as actively participate in the implementation of public tasks assumed from the state and intend to become cooperation partners for all public and non-public actors, working in the area.

Equal opportunities must be guaranteed by strengthening the service type of institutional care, building, modernising and changing institutions, and strengthening the organisation of integrated services in accordance with the residential environment.

Between 2004 and 2006, our Ministry intends to launch and develop new types of model programmes and services, which have not existed before, and with the help of which people with severe and multiple disabilities, such as blind and autistic individuals, will also have access to support which will result in their successful rehabilitation and will create the foundations of their independent lives.



Model programmes for regional sign language interpretation centres.

The objective of this programme is to continue to provide the special service launched in 2003 to compensate deaf people and people with hearing deficiencies for their disadvantages arising from communication barriers. We support the operation of this service established at regional levels (nationwide).

Promotion of infrastructure development of services supporting social inclusion of persons with disabilities.

The Ministry and the Structural Funds Programme Office have issued calls for applications for the development of services involving daytime care for disabled people. This programme will provide assistance to the user of services, as well as their families in coordinating their family obligations with those at the workplace, and will also assist in their participation in the labour market. Two groups enjoy priority in granting the support: institutions and organisations providing daytime care for severely or increasingly disabled individuals, and regional centres with rehabilitation services for people who have lost their eyesight

A system of services for autistic individuals.

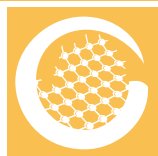
Upon the initiative of representatives of the advocacy group of autistic persons, it will be possible this year to create a centre providing complex services and assisting the rehabilitation of autistic children and adults. The Ministry plans to establish regional autism centres at two sites in the framework of a model programme in 2004. Within the programme an institution would be established where the examination staff concluding the right diagnosis, the conditions for development and education premises can be found in one place. Further social integration of young adults after the compulsory schooling age could take place with the help of the social care system (daytime institutions, residential homes, support service).

The Ministry still considers regular dialogue with advocacy groups representing disabled people and relevant civil organisations very important. Outstanding fora of such activities include the National Disability Council and the Civil Workshop assisting the Council in its activities. In order to have an effective system of services for disabled people local small and regional civil organisations are needed which, in addition to interest representation and advocacy, take an active role in public tasks too, and would like to become cooperation partners for all public and non-public actors operating in this area.

From next year a significantly higher amount of funds will be available for grant applications for services provided by advocacy organisations and groups than this year. The Structural Funds of the European Union, and the National Civil Basic Programme will provide funds for civil organisations, including also organisations representing the interests of disabled people, as a result of which civil organisations will be able to increase their participation in the delivery of public tasks within the society.

From 1 July 2004, new parking licences will be introduced which will be accepted in other countries, primarily in the territory of the European Union as equivalent with the licences issued in the given Member State.

The scope of eligibility for this parking licence will be significantly expanded, too, and beneficiaries will include blind and autistic people, people with severe mental deficiencies and visual impairment, i.e. persons restricted in movement due to reasons other than diseases of their locomotor organs.



Development of services for the homeless

At the moment there are between 30,000 and 35,000 homeless people in Hungary, of whom 20,000 live in Budapest. Nearly 8,000 accommodation facilities are operated in the whole country, and 5,000 individuals are served daily in day shelters and soup kitchens, but during the winter months these services have proved to be inadequate for years. In the recent years street work has played a more and more important role in services for the homeless. Social workers have an extremely important role in winter, when their effective activities can prevent direct danger of life, or long-term health damages. At the moment there are 100 social service organisations operating in the large towns of the country. Since 2003, this service must be provided in all settlements with more than 10,000 inhabitants.

Since 1 January 2004, around-the-clock health centres have been created at 6 regional locations and 4 Budapest sites, of which the first four centres have already started their operation supplemented with a Mobile Medical Service. These centres operate as a background service for street social work offering emergency services, disinfecting baths, observation and nursing care.

The priorities of the National Development Plan also include development of day care. The development of the services of institutions currently described as day shelters, and integration of already existing models are of key importance, because only a fragment of homeless people use the accommodation facilities, thus the best opportunity for establishing contact could be provided in a day service system with a wide range of services. In addition to the bathing, washing and cooking opportunities involved in the currently available day services we would like to provide information services, luggage guarding services, to supply a postal address, legal assistance, access to computers and internet, job search and training.

In order to coordinate the technical activities of organisations working with the homeless, to improve the quality of professional work, to allocate resources effectively, and to decentralise decisions, methodology institutions were created in the seven statistical regions of the country in 2003 with regional competence.

Dispatcher centres receive reports from the population; they take measures and coordinate street social work too. They have up-to-date information on the free beds available in the region, the services provided in the service system and eventual access to them.

In recent years, the Ministry has launched several programmes for the rehabilitation of homeless people, of which the model experiment promoting the employment of homeless people, started in 2000, stands out in importance. During the model experiment the participating organisations obtained working methods, procedures, capabilities and skills, developed relations, with the help of which modern and effective work rehabilitation can be achieved.

Housing is of key importance, without which no rehabilitation can be successful. The Ministry already provided an opportunity for organisations serving the homeless in 2003 to provide housing support for people capable of living their own lives, thus increasing the number of people overcoming homelessness. In the near future the efforts of the Ministry will be reflected in a wider access to housing support, and availability of cheap and subsidised housing facilities.



FAMILY AFFAIRS

Family support system

In a wider sense support of families is based on a multi-pillar system in the Hungarian society, the elements of which are legal regulations prepared in the spirit of the Constitution. This system cannot be limited to family support services proper only.

The services supporting families were re-regulated in 1998, when a new act was passed which declared that families are the basic units in society, and one of the most important tasks of the state is to provide diversified help for families, and improve the safety of family life and conditions of raising children. The effective act contains the following main solutions for improving the conditions of raising children.

Perhaps the most important element of the act is that the benefits pursuant to the Family Support Act are offered as of universal right; the amount of the benefits is defined by law, and they do not depend on considerations by the authorities (local government) or the income of the eligible individual; if the criteria specified by law exist, the amount defined in the regulations has to be paid out.

With regard to benefits the act differentiates in the amount of support according to the number of children, including consideration of twins; it also differentiates according to the health status of care recipients, in so far as it tries to offset the more difficult situation of children or persons of age with long-term illness and severe disability; according to the completeness of the families, in an effort to compensate the more disadvantageous conditions of single parents raising children.

On the basis of the act on family support families raising children may apply for four types of support. Eligibility for family allowance lasts until the child enters the mandatory school attendance age. Family allowance is also payable for individuals without a regular income who study in higher education institutions or participate in the first accredited higher level vocational training in a school system or participate in university or collage training. Since 1 September 2002 the amount of family allowance has been HUF 4,600 for families with one child, it is highest (HUF 12,600) on behalf of an individual with long-term illness or severe disability, and in the case of the most frequent family type, i.e. family with two children, the family allowance is HUF 5,600 per child. The amount of the allowance increases up to three children, and amounts to HUF 7,100 per child for families with three or more children. In the case of single parents the amount paid on behalf of each child is higher, and the Act also interprets the concept of single parenting extensively, and provides that parents or guardians whose spouse or common-law partner performs military or civil services, or e.g. does not have any income, is a recipient of pension, or support related to his/her social situation or health status are to be considered single parents.

The act on family support lists the benefits called childcare allowance (GYES) and child raising support (GYET) under the title of childcare support. It is a guiding principle that only one of these types of support may be paid and only for one parent. Their monthly amount is identical with the lowest amount of old-age pension at any time, and it can be twice as much for childcare benefit payable for twins. In the case of both benefits, the eligibility period is shorter than for family allowance, and while they are paid, the income earning activities of the eligible parent are restricted in accordance with the act. Generally childcare allowance is payable until the child reaches 3 years of age, but in the case of twins it is extended to the year in which the children enter the mandatory school attendance age, while it is payable until the 10th birthday of a child with long-term illness or severe disability. For reasons of equity, the competent minister



may also establish or extend this period, especially in case of difficult subsistence of the family, or in consideration of the illness or severe disability of the child; in the latter case the benefit may be paid until the child reaches 14 years of age.

The child raising support may be paid to parents, foster parents or guardians, who raise three or more children in their households, and the support is available between the 3rd and 8th birthdays of the youngest child.

While the family allowance, childcare allowance and child raising support represent support payable regularly up to a specific date, or specific criterion arises, the fourth type of benefit referred to in the Family Support Act, i.e. maternity benefit, is a one-time benefit paid to a mother after confinement, with eligibility being subject to attendance of antenatal consultations at least 4 times during pregnancy. Currently, the amount of maternity benefit equals 2.25 times the lowest amount of old age pension on behalf of a child, and in the case of twins it is three times this amount.

Benefits available on insurance basis

According to the effective legislation benefits available on insurance basis include pregnancy-confinement benefit and childcare benefit (GYED). On the basis of the insurance principle these services are only available for insured people, which means that at the time of eligibility the individual concerned must have been insured for at least 180 days, and for purposes of calculating the benefit, the amount based on which the individual paid the health insurance contribution needs to be taken into account as income.

The pregnancy-confinement benefit and childcare benefit are practically sickness-pay type benefits. The first one is payable to women who take a baby for adoption purposes during the term of maternity leave, providing that the insurance criteria are met. The childcare benefit may be paid after the maternity-confinement benefit until the 2nd birthday of the child. Both benefit amounts are calculated on the basis of 70% of the daily average earnings. The amount of both benefits is capped, and none of them may be higher than twice the minimum wage applicable on the first day of eligibility (in the case of childcare benefit the exact amount is defined in the Budget Act).

Other types of family support

Family support available as of right and not on an insurance basis include aid types, regulated in the Child Protection Act (regular and one-time child protection benefit).

Tax allowances for children were re-introduced in the tax system in the year 2000. On the basis of their volume, the tax allowance is the second most important family support tool after family allowance.

Child protection system

The new Child Protection Act, Act XXXI of 1997 on the protection of children and guardianship administration was passed by the Hungarian Parliament on 22 April 1997. The regulation aiming at child protection is based on the Constitution, creating a general framework for the protection of children, young people and families. The Convention on the Rights of the Child, adopted in New York on 20 November 1989 restricts the wide framework defined by the Constitution. This Convention was promulgated in Hungary in Act 64 of 1991, and rights of the child set forth therein represent the basis of the currently prevailing child protection regulation. The Convention determines the special civil, economic, cultural,



social and political rights of children from the point of their position in the society based on age. The act regulates special protection of children in families and society (separate provisions covering the special needs of adopted children, disabled children and children belonging to minorities), rules to be applied in extraordinary situations (military conflicts, refugee status), and also designates the international organisations supervising the protection of children's rights.

The effective regulation focuses on the enforcement of interests and rights of children, and consequently it gives priority to children being raised in families. The use of benefits defined by law is generally voluntary, the parents or other legal representatives of children can only be forced to use them in certain specific cases.

Children are protected with cash, in-kind and personal care services, primary child welfare services and child protection specialist services, as well as regulatory measures defined in the Child Protection Act. The operation of the child protection system is the responsibility of the state and local governments.

Primary services

The objective of primary child welfare services is to provide services for children and their families in their homes, which prevent the development of risks, assist the elimination of existing risks, and support the physical, mental, emotional and moral development and welfare of children, and their education within families. These services are available on a voluntary basis.

A nursery is an institution providing daytime care and education for children below the age of 3, raised in families. Once a child is over the age of 3, but if, on the basis of his level of physical or mental development, he is not mature for kindergarten education yet, he may stay in the nursery until 31 August after his 4th birthday.

A nursery may also provide habilitation and rehabilitation type education and care for disabled children too. In the framework of nursery care, disabled children may be subject to early development and care until their 6th birthday, based on the special opinion of experts or rehabilitation committee, or the child should participate in the development training.

A family day-care service is daytime care for children raised in families, not participating in nursery or kindergarten education, or children attending school, outside the opening hours of school, or children not using the daytime facilities or study rooms of schools, provided in a family environment. This type of service contains daytime supervision care, education, meals and lessons for children in accordance with their age. If the service is organised by a self-employed entrepreneur, one entrepreneur may care for 5 children.

Child protection specialist care

The child protection system has a dual function: on the one hand, through the primary child welfare services to be arranged for by local governments, it assists the development of children in families, and prevention and treatment of risky situations in life and, on the other hand, it provides a family replacing family model type service for children who cannot be raised in their own families due to some reason, which guarantees the education of the child in accordance with his age, and creates a basis for the social integration of the child.



According to Act 31 of 1997 on child protection and guardianship administration, the child protection specialist care system must provide a home for temporarily placed children subject to temporary or long-term education, follow-up care of young adults, and fully comprehensive services for children using the specialist care due to other reasons. The objective of services in children's homes is to provide the full range of services, family care and follow-up care for children and young adults in children's homes.

The child protection special service is responsible for testing the personality of the child, appointment of the foster parents or children's homes, operation of a foster parent network, or technical preparations for adoption during temporary and long-term education as well as after temporary placements. The child protection service also operates as the guardian of children subject to temporary and long-term education, preparing an individual care and education plan, providing family and follow-up care for the child in order to help him to return to his family and live his own life.

The number of children and young adults subject to child protection care varied around 20,000 in the recent years. In 1999 in total 19,887 children were placed in children's homes and with foster parents, but their number increased to 20,008 in 2000 and 20,644 in 2001. Their majority was subject to temporary and long-term education, representing 77% in 2002. Nearly 20% of the total number of such children received follow-up care. There has been a slight increase in the number of children placed with foster parent since 1990, and their proportion increased from 47.6% to 51.2% in 2002.

One of the most effective forms of child protection care is foster parent care. The number of children placed with foster parents has been slowly but gradually increase since 1995. The development of the foster parent network is an important objective, with special consideration to professional foster parent services, in order to find a placement for children struggling with various problems needing special services and joining the system an older age. Development of a special children's home network at county and national level is also a very important task especially for children with special needs, serious behaviour or problems, dissocial symptoms, physiological disturbances or use of psychoactive substances. A process started in which children's homes carrying for many children are turned into homes to place children who cannot be placed to foster parents, and do not require any special services.

Managing the integration, behavioural and socialisation problems of children in the age bracket of 14-18 years is an important challenge for both primary and specialist care. In the present child protection system, the background supported with appropriate services is not available for this age group. If children join the system at an older age, it is very likely that the problems, which have not been solved in their families for a long time, will remain open, which can also deteriorate the efficiencies the child protection services.

Finding a solution for the housing problems of young adults leaving these homes, and the other important basic condition of social integration, employment also represent problems. It is an important task to find alternative training options which assist young people to find favourable positions in the labour market; thereby follow-up care might become an effective tool, not only extending the time required for leaving the care.

Family policy for security

The Government programme announcing a welfare turn sets a target developing a family and child policy with security, targeted benefits and stronger solidarity. For the Ministry it is absolutely necessary to develop the child protection reform, and the child welfare and protection system, taking into account the individual needs of children and equal opportunities.



Within the child protection sector, differentiated services will be established via a grant application system offered for local governments mandated to fulfil these tasks, as well as for faith-based and civil organisations taking part in fulfilling these tasks.

In the framework of primary child welfare service development our Ministry shall provide support to the following

locally initiated programmes that aim at creating equal opportunities for young children (0-6 years) providing complex support to families raising small children in disadvantaged regions; special family services, preventing and treating violence within families, social work in hospitals for child protection services, and establishment of new services. Assistance of young mothers in a social crisis and their babies, as well as detection of cases of child abuse; publications related to violence against children; establishment of temporary homes providing temporary care for children, and accepting homeless families, and abused mothers.

The Ministry shall provide support, based on grant applications, for the development of institutions providing child protection special care, children's homes offering a home for disabled children subject to child protection care, establishment of special children's homes for children with physiological and dissocial symptoms, and taking psychoactive substances, already subject to child protection care, improvement of the operating conditions of the foster parent network, including the establishment of networks undertaking special foster parent services.

Those subject to child protection care will be able to rely on children's rights advocates who will start their activities in the near future and assist them in the enforcement of their rights and finding remedy for their claims.

Child protection coordinators started their work in county guardianship offices last year. These officers coordinate crime prevention programmes in the counties, which are organised for children and young people at risk and those who have already committed a crime.

The various types of financial aid under different entitlements also increase social security of families with children. Of these services the most important one is family allowance, which is a monthly state contribution to the expenses of child-raising. In 2003, more than 2 million children benefited from this type of support. After an increase of 28% in 2003, this year the family allowance will grow on average by 5.5%, which means that it has retained its real value.

In August 2002, the family allowance for the 13th month was also introduced, reducing the burden at the beginning of school. This increases the family allowance amount by more than 8%.

To ease the financial problems of parents with small children, grandparents are eligible to child care allowance, while retaining their full old-age pension, instead of their children, as a result of which young parents can go back to work. The annual 6.3% increase of maternity benefit and child care allowance in 2004 helps to retain the real value of the benefit. The real value of regular child protection support also increases. Since January 2004, children of parents eligible for regular child protection support receive meals free of charge in nurseries.



THE PENSION SYSTEM

The Hungarian pension system has a history of nearly a century. Similarly to many developed countries, after – and a consequence of – World War II the previous fully-funded system was converted into a pay-as-you-go system, which allowed for its standardisation, and by 1975 it gradually grew to cover all persons who had income from work. By the turn of the 1980's and 1990's its problems became obvious, which was aggravated by the economic crisis that accompanied the change of the political regime (the country lost one-fifth of its gross national product in a short time), the unemployment that followed in its wake from which nearly complete generations ran away into early retirement while the number of contribution payers declined steeply. In the absence of an appropriate social net the pension system was forced to perform social tasks in the first half of the 1990's. The gradual reforms launched at the beginning of the 1990s served to ensure financial equilibrium, and on the other hand, were aimed at reducing the weight of the social-redistribution elements. In 1998 the pension system was changed into what is called a system of mixed funding; in addition to the pay-as-you-go social insurance pillar and a fully-funded second pillar appeared.

The first pillar

The first pillar of the pension system, the so-called social insurance pension system is a pay-as-you-go defined benefit scheme. Money to be paid as pensions is covered primarily by the pension insurance and pension contribution collected from employers and the insured (employees) to the Pension Insurance Fund (P Fund), but the P Fund is also given significant subsidies from the budget due to its deficit, while cover for more than two-thirds of pensions for the disabled is transferred by the Health Insurance Fund (H Fund) to the P Fund. (The underlying consideration is that loss of the ability to work prior to retirement age is a health care problem the cost of which should be borne by the H Fund until retirement age is reached.) In addition to pensions, the P Fund's manager, the National Pension Insurance Directorate (NPID) also disburses so-called regular social benefits in a pension system, whose funding is provided by the central budget.

The social insurance pension system provides pensions for pensioners in their own right and based on rights acquired by relatives. Pensions in own right are old age pension, disability pension and pension for disability from accident. Pensions in the right of the relative are surviving spouse's pension, orphan's allowance, parent's pension and pensions for relatives involved in accidents. The pension of those entitled to several types of pensions is determined taking into account the rules of what is called joint payment, and are not simply added up. The exception to this is the new surviving spouse's pension determined in addition to pension in the person's own right.

Pensions

Those who have reached the age of 62 years and accumulated at least 20 years of service are entitled to old age pension. The retirement age was increased to 62 years in 1997 (before that, it was 60 for men and 55 year for women), but it was introduced after a transition period: this is applicable to men from 2001 and to women from 2009. The 62-year retirement age limit is considered to be low in international comparison (in general, it is 65 years in the EU), but for the time being, this is justified by the bad health status of the Hungarian population as well as their life expectancy, which is several years less than for



the citizens of other Member States. Until 2008 it is possible to determine a so-called partial pension for those who have reached retirement age and accumulated at least 15 years in service.

The amount of old age pension is determined, depending on years in service and the monthly average income that may be taken into account. In addition to service time, the period for which income is taken into account and the income earned during this period are important for the purposes of determining pension. The starting date of the period for taking into account income is 1 January 1988, and the monthly average of gross income earned (paid) until the starting date of pension serve as the basis of the pension determined. The period for which income is taken into account is extended by one year every year, so in a few decades, income earned during the person's complete lifetime will serve as the basis of determining pension.

The method for the regular annual increases in pension was determined in the scope of the pension reform in 1997, and after a few years of transition, the increase will be made by the so-called Swiss indexing: pensions determined more than one year ago are increased by a rate equivalent to the unweighted average of planned consumer price increase for the given year and the planned increase in national net average income.

The second pillar

For career beginners, it is mandatory to join one of the private pension funds, which constitute the second pillar of the pension system; for non-beginners, it is optional (until 31 August 1998 and from 1 January 2003 for those who have not reached the age 30 years on that date). The rules for determining pension under the first pillar valid from 2013 differ for those who pay only to the first pillar and those who pay to both the first and second pillar in that for the former, 1.65% and the latter, 1.22% of the monthly gross average income is added to the monthly pension after each year of service.

The number of persons receiving pensions increased by 394,000 between 1990 and 2003; it was 2,770,000 in 2003, though this figure was higher at times within the period (the peak was 1999, with 2,836,000 persons). The increase is characteristic of all categories except for pensions for relatives (excluding orphan's allowance). The most dynamic increase was seen in disability pension before retirement age, which doubled over more than a decade. Despite the government's efforts disability pension is related to unemployment: the proportion of those declared to have disabilities is higher in places where unemployment is higher.

A life in dignity for everyone – pensioners, pension benefits

The technical and conceptual proposals for developing the social insurance pension system, and within that, the proposals for increasing pensions and modernising the pension sub-systems (old age, disability, and relatives' sub-systems) are elaborated by the Ministry of Health, Social and Family Affairs. It makes proposals on the changes to the social insurance pension system, for increasing pensions, and the pension measures formulated in the government programme. It keeps continuous track of the standard of social insurance pensions, performs analyses and evaluations of the development of the distribution and purchasing power of pensions, and elaborates the provisions related to the pension insurance scheme of international social security agreements.



Matters related to the pension system remained within national jurisdiction also after accession. However, it is important to be able to harmonise national policies in order to implement economic and employment objectives, and not in the least, to strengthen social cohesion. The new open method for EU coordination provides a framework for this, which may be used to promote steps aimed at achieving strategic objectives.

After employment policy and social policy, Hungary now joined the European Union's open coordination process also in respect of pension systems.

Challenges expected in the future

The level of pensions may be described by the fact that during the 90's, in the course of the economic transitions, pensions increased at a lower rate than income. In spite of this, the relative income position of pensioners improved compared to the total population due to the great decrease in employment and the greater devaluation of unemployment benefits and family support. Pensions play a significant role in mitigating poverty, thanks to the pension minimum guaranteed by the social insurance pillar.

The corrections during the 90's and the structural pension reform introduced in 1998 made a part of problems concerning the pension system manageable, while challenges continue to exist in several fields. The challenges to the sustainability of the pension system arising due to the low employment ratio and for demographic reasons will increase in the future. The answers to be formulated in connection with this are: extending the active lifetime, promoting continued work and issues of gender equality within the pension scheme. The shrinking benefit fund and contribution payment evasion continue to be significant problems, therefore strengthening the relationship between contribution payments and benefits and increasing the transparency and predictability of the pension system continue to be objectives to be achieved.

An important goal for the future is to strengthen the guarantee elements of the pension system and to reduce the risks of poverty in old age by permanently ensuring the constant value of pensions. On the other hand, it is important to harmonise the coverage assumption and regulations for the private pension pillar and the state pillar.

Results of the welfare turn in the field of pensions. The most important expected pension measures

In January 2004, pensions increased by 6.3%, taking into account the 6.8% increase in net income and 5.8% increase in prices. If necessary, the pension increase may be adjusted by the pensioner price index corresponding to the consumption habits of the elderly in November 2004.

The total pension increase during the year will be 8.4%, which represents a 2.5% increase in purchasing power, given the 5.8% increase in consumer prices.

In November 2004, surviving spouse's pensions payable in addition to pensions in own right will be increased by another 20%. The implementation of the new increase of surviving spouse's pensions will realise the altogether 50% increase as promised in the government programme, affecting nearly 500,000 persons and providing them surplus of altogether about HUF 35 billion.



THE ROLE OF THE CIVIL SECTOR

The government intends to assign an important role to civil society representing the interests of communities of citizens and business organisation and considers them a partner in shaping and determining the government's goals. They have an equally significant weight in performing policy as well as interest representation tasks, and in meeting the strategic goals of health care and social policy together with state and municipalities. The civil societies have a right to be represented on the National Health Council, the National Council for Disability Affairs and the National Council for Elderly Affairs; in addition to these fora other models of civil dialogue are also emerging.

The parliamentary debate days related to special programmes, the internet fora that allowed for learning about and commenting on draft legislation, and conference-type events that allow for targeted dialogue constitute important venues for the Ministry of Health, Social and Family Affairs to keep contact with civil societies.

The purpose of the process launched in line with the draft civil strategy of the government and the Ministry is to strengthen the civil societies providing services and interest representation in the field of health care and social affairs in order to develop the sector, and to develop regular and efficient cooperation. The basic document for this is the Concept of Collaboration, which made a proposal for the principles of cooperation between the Ministry of Health, Social and Family Affairs and civil interest representation, social and welfare non-profit service providers, renewing the system of dialogue and developing civil relations.

Objectives:

- to renew relations between the Ministry and non-profit organisations, to develop consensus and to put the system of professional dialogue and reconciliation on a new foundation,
- to organise and maintain fora for publicity and create the conditions for interactivity.

The Ministry's strategic partner organisations are national umbrella organisations. Their professional relations and network experience provide the guarantee for efficient mediation between the Ministry and civil societies, promoting the development of horizontal relations and providing differentiated professional services in line with the task performed by the different types of organisations.

Professional interest reconciliation fora have been in operation again since the autumn of 2002: these are the Interest Reconciliation Council for the Health Care and Social Sector, the Social Committee of the National Interest Reconciliation Council and the Social Council.

The Interest Reconciliation Council for the Health Care and Social Sector provides the forum for interest reconciliation on matters related to working in the sector, the living and working conditions of the sector's employees. In addition, the Council comments on concepts and decisions as well as draft legislation at national and sectoral level, which concerns the work done by employees.

The National Interest Reconciliation Council is the most comprehensive forum for trilateral negotiations, and one of its specialist committees is the Social Committee operated by the relevant ministry. The purpose and task of the Committee is to promote the exploring of interests, efforts and conflicts of the government, employers and employees on matters concerning the world of work and related to special policy, to facilitate reconciliation and to reach macro-level agreements.



The task of the Social Council is to promote the awareness of an reconciliation on the different efforts, as well as approaching of positions in preparing legislation work concerning the social field.

The National Health Care Council assists the Government in performing tasks related to health care organisation and management, and provides initiatives, makes proposals, comments and gives advice on the development of the government's health policy, and performs analysis and evaluation activities in the process of implementing the government's health policy decisions. Established on 19 January 1999, the National Council for Disability Affairs assists the Government's work related to the disabled, comments on draft legislation concerning disabled people, makes proposals on decisions, programmes and legal regulations to be made in connection with them. There is a Civil Workshop in operation next to the Council, comprising nearly a hundred organisations acting in the interest of people with disabilities.

Cooperation and common legislation work is justified not only by the government's intentions but the data on the typical operation of the civil sector. According to data from the CSO, in 2000 altogether 2,111 foundations and non-profit organisations performed health care activities, meaning 4.5% of all organisations in the Hungarian non-profit sector. Most of them operated in the form of foundations. Foundations were set up mostly to support health care institutions, hospitals and hospital wards (improving infrastructure, purchasing machinery and instruments, supporting hospital and institutional care). The activities of foundations set up for public health purposes are manifold and they include foundations related to providing health care, developing and educating the population but also include organisations dealing with the maintenance of health, a healthy lifestyle, informing and educating young people as well as the general development of public health.

There are altogether 4,137 civil organisations working in social care, which is 8.7% of all organisations, most of them also in the form of foundations; 21% of foundations supported people with impaired health (people with physical disabilities, mental disabilities, chronic patients, vision and hearing impaired, diabetes patients, renal patients, etc.), 21% served to support protecting children and young persons, 12% supported the needy (the homeless, refugees, the poor) and 11% supported the elderly.

The largest number of non-profit organisations with more than one member consisted of organisations supporting people with impaired health, but the number of those engaged in family protection, primarily supporting large families is also high.

The Social Act provides that civil or non-profit sectors may also participate in providing social care that grants personal care, provided they are able to ensure appropriate conditions for the people they care for.

All in all, it may be said that the relationship between the Ministry and civil organisations is developing dynamically and that new forms of collaboration keep emerging.

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